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ABSTRACT

This document presents the proceedings of a conference on geriatric education. These papers are included: Promoting Healthy Aging: A Leadership Role for Geriatric Education; National Research Priorities in Aging; Aging with a Disability; Recent Advances in Clinical Strategies in Geriatric Education: The Role of the Geriatric Nurse in the Acute Care Setting; Interdisciplinary Geriatric Education: Implications for Educators; The Curved Bristle Toothbrush: Designed for Assisted Brushing; Evaluation of Nutritional Status of Nursing Home Residents; Characterization of Anorexia in Nursing Home Patients; Accidents, The Elderly, and The 'Golden Years'; Older Adults as Caregivers and Care Recipients; Development of an Instrument to Measure Serenity; Effectiveness of Leadership Style in a Small Group Sex Education Workshop for the Elderly; An Ethnographic Study of the Effects of Institutionalization on Social Integration in a Life Care Community; An Assessment of the Drug Therapy Education Needs of an Interdisciplinary Group Interested in the Elderly; A Model of a Community College/Nursing Home Partnership by Means of Instructional Television Fixed Services; An Approach to Teaching Stress Management for Gerontology Practice; Prolegomenon to the Study of Aging; Teaching Intercultural Attitudes to Aging Through Literature; Humor as an Innovative Method for Teaching Sensitive Subjects; Assessing the Curriculum Relative to Aging Content; Incorporating Geriatric and Gerontological Content into the Baccalaureate Nursing Curriculum; Faculty Retiree Development as a Resource for University/Community Collaboration; Fostering Interdisciplinary Collegiality in Gerontology through Summer Faculty Internships; A University/Community Partnership: Development of a Community Nursing Service; The Use of Popular Print Media Visuals To Dispel Common Negative Attitudes Toward Older Adults. Materials from nine workshops with objectives listed are included. (ABL)

Ohio Valley Appalachia Regional Geriatric Education Center

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1989 Summer Geriatric Institute

DEVELOPING LEADERSHIP IN GERIATRIC EDUCATION

An Annual Faculty Institute

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July 24-27, 1989
The Hyatt Regency
Lexington, Kentucky

The Ohio Valley Appalachia Regional Geriatric Education Center

Developing Leadership in Geriatric Education

Proceedings of the Fourth Annual Summer Geriatric Institute

Davis L. Gardner, Editor

Margaret C. Hoekelman, Assistant Editor

Proceedings

July 24-27, 1989
Lexington, Kentucky

The Summer Geriatric Institute is funded in part by the USDHHS, Health Resources and Services Administration, U.S. Public Health Services, Bureau of Health Professions.

PREFACE

The invited Institute faculty presentations and the concurrent paper sessions by the authors of refereed papers combined for a very successful Fourth Summer Geriatric Institute conducted by the Ohio Valley Appalachia Regional Geriatric Education Center [OVAR/GEC] at the Hyatt Regency in Lexington, Kentucky, July 24-27, 1989. Administratively based at the University of Kentucky A. B. Chandler Medical Center, OVAR/GEC is a unique consortium offering a variety of programmatic activities and resources in geriatric education. The five consortium members are the Universities of Cincinnati, Kentucky, and Louisville; and East Tennessee State and West Virginia Universities.

The four OVAR/GEC Summer Geriatric Institutes (1986-1989) continue to focus on the theme of **DEVELOPING LEADERSHIP IN GERIATRIC EDUCATION**, a theme congruent with the missions set forth for the Geriatric Education Centers [GECs] to stimulate faculty development in geriatrics. Thirty-three GECs currently are funded by the U. S. Department of Health and Human Services' Bureau of Health Professions, Health Resources and Services Administration.

As in previous Institutes, the 1989 Institute's design continued to encourage interaction among the 97 participants from a variety of health care professions. The faculty members and clinicians attending the Institute were from 29 institutions in 18 states. The sessions of the Institute were intended to address the Institute's six primary goals:

1. to expand faculty leadership in geriatric/gerontologic education and networking among academic and clinical faculties in the health professions;

2. to extend the general knowledge base about older adults in areas of healthy aging and rehabilitation, and as consumers of health services;

3. to provide an interactive forum for the discussion of national research priorities and for the exchange of research studies and expertise in geriatrics/gerontology;

4. to enhance knowledge and understanding of innovative approaches in classroom and clinical instruction and of program and faculty development strategies in geriatric/gerontologic education;

5. to promote discussions of the concepts and issues of geriatric/gerontologic education that incorporate interdisciplinary approaches; and

6. to provide each participant with a Summer Geriatric Institute notebook that offers valuable resource information and materials on each Institute session.

The 1989 Proceedings is organized into topical sections that focus on the Institute's contents in relation to the goals. The specific objectives for each section, as stated in the Institute notebook, precede the papers in that section. The first papers in the Proceedings are those from the plenary sessions. These are followed by twenty refereed papers which are organized topically so that the research studies in aging are together, as are papers on innovative approaches in geriatrics education, and papers on faculty development models. Papers from concurrent workshops are included were available. An index of presenters concludes the Proceedings.

Papers are printed in the Proceedings from the copy provided by the authors. The Table of Contents, each section's introductory page, and the Index of Presenters provide institutional affiliations; please correspond directly with the author(s) if you desire more information about the paper(s).

The Institute's plenary sessions included two addresses that are not printed in the Proceedings. "National Research Priorities in Aging" was the topic addressed by Gene D. Cohen, M.D., Ph.D., Deputy Director of the National Institute on Aging, and by William R. Markesbery, M.D., Director of the University of Kentucky's Sanders-Brown Center on Aging and OVAR/GEC Director.

Dr. Cohen's excellent presentation addressed four main areas: (1) aging versus illness; (2) modification of illness by medical and psychosocial factors; (3) changes in normal aging in the absence of illness; and (4) the broad range of NIA research interests. Participants will remember the illustrations and literary quotations that Dr. Cohen incorporated into his presentation. His poignant concluding presentation of Charles Dickens' Scrooge as a classic 19th Century case of a depressed, hostile, paranoid old man who drastically interfered with the lives of others also should be in our memories as we work with 20th and 21st Century geriatric patients.

Dr. Markesbery commented on the seven research priorities in Alzheimer's Disease (AD) and related memory disorders: (1) definitive laboratory diagnostic studies; (2) protein chemistry; (3) genetic aspects of AD; (4) epidemiology of AD; (5) molecular membrane studies; (6) calcium metabolism studies; and (7) blood vessel and cerebral changes. He also outlined the four essentials for successful grant writing: (1) good ideas (a MUST!) (2) a reasonable hypothesis that reflects the good ideas; (3) a clear, simple proposal that maintains a focus of the reviewer; and (4) a reasonable budget. He concluded with seven major corollaries of unsuccessful proposals.

Seven authors of the refereed paper presentations published in the Proceedings have been invited to expand their papers for publication in Educational Gerontology: An International Bimonthly, Volume 16, Number 3. The projected publication date is July/August 1990. Educational Gerontology (Volume 15, Number 4, July/August 1989) contains selected papers from the OVAR/GEC 1988 Summer Geriatric Institute. The invitation has been accepted to have one 1991 Educational Gerontology issue publish selected papers from those to be presented at the July 1990 OVAR/GEC Summer Geriatric Institute.

The variety and scope of the educational opportunities available made this Institute particularly noteworthy and worthwhile. The OVAR/GEC annual Institutes are made possible by federal grant support, by participant registration fees, and by support from the consortium's member institutions. In addition, the 1989 Institute received financial support from Upjohn Pharmaceuticals and support for one speaker from Glaxo Pharmaceuticals, Allen & Hanburys Division. OVAR/GEC sincerely appreciates the interest these two firms have in faculty development in geriatrics and their contributions to the 1989 Summer Geriatric Institute.

The excellent support from the OVAR/GEC staff, Arleen Johnson--OVAR/GEC Project Manager, Linda C. Brasfield--OVAR/GEC Co-Director, the OVAR/GEC Institutional Representatives, the Core Faculty members, and OVAR/GEC Director Dr. Markesbery demonstrate what teamwork, collaboration, and lots of hard work can accomplish. Finally, the competent assistance of staff members June Horn and Arleen Johnson have facilitated the prompt publication and distribution of this Proceedings. We sincerely thank everyone for making the 1989 Summer Geriatric Institute a success!

Davis L. Gardner
OVAR/GEC Co-Director, and
Summer Geriatric Institute Director

Margaret C. Hoekelman
OVAR/GEC Information Specialist

September 1989

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PROMOTING HEALTHY AGING: A LEADERSHIP ROLE FOR GERIATRIC EDUCATION

LINDA C. CAMPANELLI, Ph.D.

HEALTH PROMOTION SUPERVISOR
AMERICAN TELEPHONE AND TELEGRAPH
OAKTON, VA

Objectives:

Upon completion of this presentation participants should be able to:

1. Enhance the Understanding of the Role of Health Promotion for an Aging Population

2. Discuss Health Promotion Programs that Meet the Needs of a Diverse Population of Older Adults

3. Discuss the Results of a National Health Promotion Needs Assessment

4. To Encourage and Motivate Health Professionals to Pursue Health Promotion Activities Through Public and Private Sector Joint Ventures

5. To Stimulate Research in the Neglected Areas of Health Promotion (i.e., Smoking Cessation)

I.

PLENARY SESSION

THE OLDER ADULT: ISSUES IN HEALTHY AGING

REACTOR PANEL

LINDA C. CAMPANELLI, Ph.D.
AMERICAN TELEPHONE AND TELEGRAPH
OAKTON, VA

ROBERT V. ACUFF, Ph.D.
EAST TENNESSEE STATE UNIVERSITY

DANIEL R. RICHARDSON, Ph.D.
UNIVERSITY OF KENTUCKY

Objectives:

Upon completion of this presentation participants should be able to:

1. Discuss the variables that make nutrition an issue in healthy aging, and identify considerations for assessing and implementing better nutrition information into the geriatric health care curricula.

2. Describe the determinants of maximal oxygen consumption and how these determinants are affected by aging and exercise conditioning.

NUTRITION AND AGING: A BRIEF OVERVIEW

by

Dr. Robert V. Acuff

Nutritional status in elderly individuals may be affected in three ways (1): first, the decline of tissue maintenance and function; second, an inclination toward chronic degenerative diseases and; third, little substantiated knowledge of nutrient requirements in aging individuals.

The elderly in general, are at risk for nutrition deficiencies (2,3). Inadequate diet and malabsorption (4), oral health (5) and taste perception (6), loss of vision (7), decreased mobility, and psychosocial aspects of aging (8,9), all impact upon the nutrition status and well-being of the aging individual. It has also been postulated that the elderly are at greater risk in developing malnutrition as a result of polypharmacy; this group is not prominent in drug abuse however, they consume marginal diets and drug-induced malnutrition is more likely to develop (2).

Currently, the Recommended Dietary Allowances (RDA) are divided into two adult groups (10). These categories are 23 to 50 years of age and 51 and older -- obviously an extremely broad range for making any type of dietary recommendations to such diverse age groups. The RDA have been primarily developed by examining the nutrient needs of young, healthy adults and extrapolating these results to the very young and old. This is unfortunate for both groups because of the non-homogeneous nature of the very young and old. It can therefore be stated that the nutritional needs of the elderly are uncertain. Although human aging has been defined in many ways, the physiological decline is

acknowledged by most to be a part of normal aging. The decline in physiological function with aging has been illustrated by Shock (11). This decline occurs asynchronously with some organs demonstrating relatively little change while other organs lose capacity rapidly with each passing decade. Even within the same individual, this complex picture may occur at different rates. It is agreed that nutrition plays an important role in this process and current research is attempting to examine this aspect.

A decline in caloric intake and energy expenditure with increasing age has been recognized (12,13). Although several factors have been postulated for an age-related decrease in basal metabolic rate (14,15,16), studies in human beings have not substantiated the postulate of energy wasteful or conservative mechanisms (17). Basal metabolic rate as a function of metabolic mass has been suggested to be stable with advancing age (16); however, a decline in lean body mass may in part explain the decrease in calorie consumption with aging (16). The anorexia of aging which further indicates that protein-calorie malnutrition is a common problem in the sick elderly individual has been described by Morley (18). Because there are no protein stores (each gram of protein serves a metabolic function) and muscle-breakdown probably proceeds slowly in the marasmic, elderly individual, weight loss is an important clinical evaluation in determining nutrition status in this group of adults. The anorexia of aging may be heralded by a decrease in the appreciation of food. The acuity of vision, taste and smell all decrease with advancing age and have an instrumental role in the anorexia of aging (6,19). In view of this, the elderly individual should be periodically evaluated for decreasing weight and adequacy of protein intake.
The current RDA (10) have established 0.8 grams of protein per kilogram of body weight per day for individuals over the age of 51 years as an adequate intake of

protein. Also, the suggestion has been made (10) that 12% or more of the total energy intake of this age group should be protein. It has been speculated that some elderly individuals, especially those with chronic diseases, may require more protein than their younger counterparts in order to achieve nitrogen balance (20). In fact, it may be appropriate to recommend as much as 1.5 - 2.0 grams of protein per kilogram of body weight per day in this group, especially in view of decreasing calorie (energy) consumption (12).

Vitamin deficiencies are more common in older age groups as than in younger individuals of the population (21). In the United Kingdom, it has been estimated that 3% of the elderly are vitamin deficient (22). Decreasing energy consumption, chronic diseases, alcohol consumption and drug-induced deficiencies all impact upon the incidence of vitamin deficiency in the elderly. Despite the recognized risks of vitamin deficiency in the elderly, nutrition surveys have not been adequate in scope, especially in those individuals over the age of 75 years. Other causes which may produce a vitamin deficiency include malabsorption, secondary aspects of disease, and the inability of the elderly to choose, as well as to obtain, appropriate food stuffs for adequate nutrition.

Exton-Smith (21) has reported that the most important clinical vitamin deficiencies in the elderly concern the B-Complex group (folate and B12), ascorbic acid, vitamin D and K. Garry et al (23) found that the vitamin C status in 270 free-living, healthy elderly individuals was adequate and less than 2% were at risk for developing clinical signs of hypovitaminosis C; however, in the same group it was noted (24) that approximately 60% of both men and women regularly ingested one or more vitamin and mineral supplements with Vitamins C and E being the choice of regular consumption.

Brin (24) has described five stages in the evolution of a vitamin deficiency. Initially there is a decrease in tissue stores, followed by a decrease in urinary excretion of the vitamin. Later, there is a reduced function in enzyme activity in which the vitamin participates as a co-enzyme. This is followed by physiological symptoms such as weight loss, impaired psychological function, malaise, and the inability to sleep. Clinical signs of the deficiency become evident at an even later stage, followed by an irreversible tissue or anatomical damage. Obviously, clinical signs appear much later in the deficiency and biochemical or physiological symptoms herald the clinical presentation.

The prevalence of malnutrition in the institutionalized or hospitalized patient has been documented (25-28). In both surgical and medical patients, the incidence of protein malnutrition as well as hypovitaminemia occurs commonly in hospitalized patients. Bienia et al (29) reported that protein-calorie malnutrition was diagnosed in 61% of geriatric (65 years and older) male patients admitted to a Veterans Administration Hospital as compared to younger patients in which protein-calorie malnutrition occurred in only 28% of the patients (younger than 65 years). In the malnourished, geriatric patient, infections were higher as well as skin-test anergy and prevalence of anemia. Further, presence of malnutrition on admission indicated a significant increase of morbidity and mortality during the hospital stay.

The techniques of nutrition assessment have been identified as imprecise and limiting (30,31). This is especially true in identifying malnutrition in the elderly (32). Although the role of malnutrition as a contributing factor to morbidity and mortality in the hospitalized patient has been recognized for a number of years (33-35), the degrees of malnutrition as well as the parameters

to assess, have yet to be standardized. However, the importance of evaluation and serial measures in the elderly should not be neglected, as this is the only current methodology for prevention.

Nutrition assessment involves several aspects and should include the patient's history, physical examination, anthropometrics, biochemical parameters, as well as interviewing the patient's family. If the family is able to relay a reliable history, it can be invaluable in assessing the nutrition status of the patient.

The patient or his/her family can relate the eating habits consistent with the patient's daily routine. Further, the number of meals per day, alcohol consumption and amounts of food consumed at a meal, all contribute to the dietary history of the patient. In patients who may be transferred from institution to institution, or in those individuals unable to recall dietary patterns, a three-day dietary evaluation can inform the care-giver and help establish a picture of current food intake.

During the physical examination, the physician can evaluate the patient for any nutrition deficiencies which may be present clinically. Protein-calorie malnutrition (marasmus) or insufficient protein (kwashiorkor) can, along with other biochemical and anthropometric tests, be diagnosed by the physician.

The clinical signs of specific vitamin deficiencies are well documented but often are neglected or forgotten. Further, clinical vitamin deficiencies may present as mild, clinical signs may be non-specific or may result from a combination of deficiencies.

Biochemical indicies which may help in the diagnosis of malnutrition include the serum albumin, total lymphocyte count, transferrin or total iron-binding capacity, total nitrogen excreted in the urine during a 24 hour period, creatinine/height index, plasma cholesterol, triglycerides, hemoglobin, and hematocrit. The majority of these biochemical components can be readily obtained from the patient's record or weekly laboratory reports. There have been a number of reports implicating the limitations of using the above tests in evaluating nutrition status (30,31); however, in context with the patient's history, physical and anthropometric assessment, can assist in determining the nutritional state of the individual.

Other biochemical tests have been introduced for evaluation of protein-calorie malnutrition; these include retinol binding protein, thyroxine-binding prealbumin and urinary 3-methyl histidine excretion (38-39).

The use of anthropometric measures in the elderly is an important part of health care (40). These measures give clinicians an evaluation of fat stores and somatic protein status, as well as an ongoing assessment of possible obesity or emaciation. Body weight loss helps in predicting the degree of malnutrition and weight loss over time (>7-10% ideal body weight) may indicate an ongoing process of chronic disease. Although body weight is easily determined, it is often overlooked or neglected. For those elderly patients who are suspected of malnutrition or in whom a decrease in appetite has been noted, weekly body weight measurements should be obtained and recorded. The weighing device should be calibrated periodically to assure accurate body weight measurements. An upright, triple - beam, balance should be used; if the patient is bedridden, or

is confined to a wheelchair, balances are available for measuring body weight under these conditions.

Triceps and subscapular skinfold thicknesses provide indirect estimates of body fat. Both measurements are made using a Lange, Holtain, or Harpenden skinfold caliber. The measurers should be familiar with performing these measurements as well as their limitations. However, if used properly, these measures can give an index of adiposity or malnutrition (41-44).

The midarm muscle circumference, along with the triceps skinfold thickness, measures midarm muscle area (45,46) using a flexible, nonstretchable tape. The measure is taken at the midarm (between the acromion and the olercranon process) at the same site as the triceps skinfold thickness is obtained.

Height (stature) should be periodically evaluated using a measuring stick or nonstretchable tape. Curvature of the spine should be noted. If an individual cannot stand upright without assistance, knee height can be used to estimate stature (47). Also, a recumbent measurement may be made by using a flexible tape, a flat board or hook and making the height measurement from head to foot.

The data can be compiled and used to form the basis of a nutritional assessment. Usually, each institution or metabolic support service develops their own evaluation form specific for their patient population.

Drug-nutrient interrelationships become pertinent in the elderly patient. As a result of other chronic ailments that elderly patients may be experiencing, the use of drugs and the patient's nutritional status should receive consideration.

Although it is not the purpose of this discussion to review drug-nutrient interactions, it is the responsibility of the care-giver to be cognizant of these relations and possible effects upon nutrition status in the elderly (48).

In summary, the nutritional requirements of the elderly still remain to a great extent an enigma. It is left to scientific investigation to determine the nutrient needs of an individual in later life and to continue the possible treatment of chronic debilitating diseases with the best nutritional care which can be offered. Through continual evaluation and nutrition assessment, the status of the elderly will be enhanced and the quality of life improved by meeting their nutritional needs and requirements.

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THE EFFECTS OF EXERCISE AND AGING ON MAXIMAL OXYGEN CONSUMPTION

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OBJECTIVE: One of the most feared aspects of aging is a loss in the ability to be physically active. One of the best indicators of a person's potential for physical activity is the maximum amount of oxygen that the body can consume during exercise.

The objective of this presentation is to describe the determinants of maximal oxygen consumption and how these determinants are affected by aging and exercise conditioning.

INTRODUCTION: The human specie is an aerobic machine in that oxidative phosphorylation (the utilization of oxygen to produce ATP) accounts for the bulk of our energy production. The ability of the human body to consume and use oxygen is considered to be one of the best, if not the best, measure of overall physical health and the potential for physical activity. In this regard the general weakening of the body associated with aging is attended by an age related reduction in the ability to intake and use oxygen. The operative phrase here is associated with aging. For the decreased ability of an older person to use oxygen is not due to aging itself as much as it is to factors associated with the aging process. What these factors are and what we can do about them is the major theme of this presentation.

The ability to consume oxygen is quantified by measuring the maximal amount of oxygen that the body can consume per minute during heavy exercise. This parameter, known as the maximal oxygen consumption, is expressed in units of ml of oxygen consumed per minute per kilogram of body weight. At this point the reader might ask: Why is maximal oxygen consumption during exercise used rather than simply oxygen consumption during rest? The answer is analogous to trying to determine the "health" of an automobile by simply letting the engine idle. This tells you very little about how the car will perform. For this it must be driven out on the open highway. In a like manner performance of the human body can not be accurately assessed with a subject sitting at rest. Under these conditions a person with one foot in the grave would show about the same performance ability as an olympic champion. O.K. so we need to get off our duffs and perform, but why maximal oxygen consumption and not something a little less strenuous? To spare you, and me, the agony of wading through 50 years of literature, suffice it to say that in searching for a measurement of performance researchers have found this to be the most accurate and reproducible measure of a human's (or any other mammal for that manner) ability to do physical work. Furthermore, with today's technology maximal oxygen consumption is relatively easy to measure. A subject simply breaths through a mask that contains oxygen sensors

which detect the concentration of oxygen in the inhaled and exhaled air. This information is usually then fed into a computer which calculates the amount of oxygen the subject is consuming while he or she is exercising on a treadmill or on a stationary bicycle. The exercise intensity is gradually increased resulting in a rise in oxygen consumption, and this process continues until the increase in oxygen consumption levels off; ie, until the maximal oxygen consumption is reached.

This presentation will discuss the determinants of maximal oxygen consumption, how these determinants, and hence maximal oxygen consumption itself, vary with age and to what extent age related changes in maximal oxygen consumption are due to aging itself vs conditions associated with the aging process.

DETERMINANTS OF MAXIMAL OXYGEN CONSUMPTION: To address this issue we will follow oxygen on its course from atmospheric air to final use by body tissues in particular that of skeletal muscle. By this scheme the first determinant of oxygen consumption is the ability of the lungs to intake oxygen at a rate equivalent to its use. A good measure of lung function is a parameter called the "vital capacity" (VC). This is defined as the total volume of air that can be voluntarily moved in one breath, from full inspiration to maximum expiration. According to a population survey by Shock (1967), VC decreases about 40 percent from age 30 to age 90. However, since this was a mixed population it is not known what portion of the decrease in VC is due to aging alone vs pulmonary diseases whose incidence increase with age such as emphysema.

After oxygen has made its way into the lungs it must diffuse from the alveoli into the blood flowing through the pulmonary capillaries that surround the alveoli. Aside from individuals who are suffering from pulmonary diseases and/or pulmonary edema there is no indication that the diffusion of oxygen from the alveoli to the blood is affected by aging.

Once oxygen enters the blood from the alveoli it flows into the left ventricle of the heart from where the oxygenated blood is pumped into the general circulatory system. Therefore, our next major determinate of maximal oxygen consumption is the ability of the left ventricle of the heart to pump blood. This ability is reflected in the maximal cardiac output which is simply the maximal amount of blood in liters per minute that the left ventricle can pump. It was once thought that beyond the age of about 30 a person's cardiac output both at rest (Shock, 1967) and maximal levels obtained during exercise (Julius et al, 1967) gradually decreased over the remainder of their life span. However, in a very careful study undertaken at the National Institute on Aging's gerontological research center in Baltimore, Rodeheffer et al (1984) showed that maximal cardiac output is not diminished in elderly who are free of cardiovascular disease. That the ability of the heart to pump blood is important to health is a rather obvious understatement. The Rodeheffer et al study pointed

out that the decrease in this ability, once thought to be an inevitable outcome of the aging process, is not due to aging at all, but rather to disease processes that are correlated with aging.

Once oxygenated blood has been pumped by the heart it must pass through the arterial vessels before reaching the tissues where the oxygen is consumed. A major disease that inhibits the flow of blood through the arterial system is atherosclerosis. This disease can affect the flow of blood to skeletal muscle and to muscles of the heart, and hence the availability of oxygen to these tissues.

In the latter case the atherosclerosis is termed coronary heart disease (CHD). A major reason for the heart loosing its ability to pump blood is CHD. Understandably, people with CHD have a reduced maximal cardiac output and hence a reduced maximal oxygen consumption. Since the incidence of CHD increases with advancing age (Widmer et al, 1964), the presence of CHD is no doubt why some elderly people do have a reduced maximal cardiac output. However, again it should be kept firmly in mind that CHD is not a manifestation of the aging process, but rather the presence of a disease, atherosclerosis.

Atherosclerosis can also occur in the arteries that supply blood to the skeletal muscles thereby limiting the transport of oxygen to this tissue. Since skeletal muscle is the major consumer of oxygen during the conditions of heavy exercise in which maximal oxygen consumption is made, it follows that atherosclerosis of skeletal muscle arteries will reduce maximal oxygen consumption. But again, although atherosclerosis of skeletal muscle arteries is more frequent in the elderly, it is not <u>due</u> to aging.

Once oxygenated blood enters via the arteries into a tissue, such as skeletal muscle, it must pass through a network of capillaries from where oxygen leaves the blood to enter into the muscle cells. Thus, the extent of the capillary network in muscle tissue is the next determinant of maximal oxygen consumption to be considered. Studies have shown that the density of capillaries in relation to the number of muscle cells being supplied decreases with age in skeletal muscle (Parizkova et al, 1971) and in heart muscle (Tomanek, 1970). This may be one reason for the age associated decrease in maximal oxygen consumption.

The use of oxygen by body tissues, in particular muscle tissue, is the end point in the journey of oxygen from atmospheric air to being used by the body. As the various cells within the tissues of the body take up oxygen the amount of oxygen in the venous blood decreases. This is reflected in the "oxygen extraction" which is the amount of oxygen in the arterial blood minus the amount of oxygen in the venous blood. By this scheme an increase in oxygen in the venous blood reflects a decrease in oxygen extraction and vice versa. It has been shown that oxygen extraction during exercise decreases with age (Julius et al, 1967). This is thought to be due to two factors: 1) a decrease in the amount of muscle tissue (Lakatta, 1986); and 2) a

decrease in the oxidative enzyme molecules within the mitochondria, or energy producing sites, of muscle cells (Young et al, 1983). Thus, a decrease in the ability to extract oxygen from the blood and use it to produce energy may be one reason why maximal oxygen consumption decreases with age. But again, it is not at all clear that this is due to aging per-se. For example, the decrease in both muscle mass and muscle oxidative enzymes with age may be due more to a sedentary life style than aging itself. Evidence, that this is the case will be presented in subsequent sections of this presentation.

To summarize this section of the presentation, the determinants of maximal oxygen consumption are: 1) the ability of the lungs to inhale atmospheric air; 2) the transport of oxygen from the alveoli to the blood capillaries surrounding the alveoli; 3) the ability of the heart to pump blood; 4) the transport of oxygenated blood through the arteries of the body; 5) the delivery of oxygenated blood to the immediate vicinity of the body cells by way of the blood capillaries; and 6) the uptake of oxygen from the blood capillaries and its use by the body cells. It was once thought that the functional ability of most if not all of these factors inevitably decreased with age. We are now relatively certain that this is not the case. While it is true that many of the aforementioned determinants of oxygen consumption do decrease with age, the decrease is not due to aging itself but to other factors associated with aging such as disease and/or disuse.

EFFECTS OF EXERCISE ON THE DETERMINANTS OF MAXIMAL OXYGEN CONSUMPTION: Like the proverbial ostrich, a person would need to have had their head in the sand over the past 20 years not to have noticed that regular exercise improves the ability to perform physical work. That is what "getting into shape" is all about, and the number of adult Americans participating in one of the more popular forms of regular exercise, jogging, increased about 16 fold between 1970 and 1982 (Jokl, 1983).

To jump to the bottom like, what regular exercise does that enables an increase in the ability to perform physical work is to improve virtually all of the determinants of maximal oxygen consumption discussed in the previous section. For an in depth treatment of this topic most text books in exercise physiology published since 1980 contain relatively up to date discussions of the physiological changes that occur with regular exercise; eg, McArdle et al (1981); Pollock et al (1984). Since this presentation is concerned with aging, we will review some of the more salient effects of regular exercise on the elderly.

One of the first, and to date one of the most thorough, studies of exercise in the elderly was performed by Herbert deVries (1970) on 52 to 88 year old volunteers who lived in a retirement community in California. He found an improvement in vital capacity of the lungs and in the amount of oxygen consumed at a particular exercise heart rate after only 6 weeks of a combined walk-jog exercise program. These results showed that the ability of the elderly to consume oxygen

can be improved by regular exercise and that at least part of this may be due to improved lung function. At about the time of deVires work an investigative team in Sweden showed a 13 percent improvement in maximal cardiac output in middle aged subjects (mean age 47 yr) with an 8 week jogging program (Hartley et al, 1969). In comparing these results to similar ones obtained in a younger group (mean age 23 yr - Ekblom et al, 1968) the Swedish group pointed out that maximal cardiac output increased from 21.5 to 23.2 L/min in the young and from 18.7 to 21.1 in the middle aged group. Thus, percentage wise the middle aged subjects improved heart performance more than did the younger group. More importantly, these data indicate that an exercised conditioned middle aged subject has the same maximal cardiac output capabilities as does a young unconditioned person, 21.1 vs 21.3 L/min. So to say that exercise makes one young at heart is not exactly a pun.

Thus far we have seen that regular exercise in the elderly improves the ability to bring in oxygen from the atmosphere (the lungs) and to pump oxygenated blood through the body (the heart). With regard to delivering oxygen to the tissues of the body via the arteries there is evidence that regular exercise may retard the development of atherosclerosis. Since this disease affects primarily the elderly (Widmer et al, 1964), it is the older person who experiences the most benefit from this aspect of physical conditioning. One of the leading risk factors in atherosclerosis seems to be high levels of plasma cholesterol in particular the cholesterol contained in the low density lipoproteins (LDL). For some reason the LDL cholesterol has a tendency to end up in blood vessels, a situation which leads to an atherosclerotic plaque. A different lipoprotein, the high density type (HDL), offers a measure of protection against atherosclerosis by promoting the return of cholesterol from the body, including from blood vessels, to the liver where cholesterol can be processed into bile (Miller and Miller, 1975). Exercise among middle aged men has been shown to increase the percent of HDL in the blood (Hartung et al, 1980) and hence reduce the risk of atherosclerosis. An other major risk factor in atherosclerosis is hypertension (Wolinsky, 1981). The study by deVries (1970) showed that regular exercise can reduce blood pressure among the elderly. Thus, by controlling plasma cholesterol and blood pressure, regular exercise probably retards the development of atherosclerosis in middle aged and older people. This no doubt improves oxygen delivery capability, a determinant of maximal oxygen consumption.

Oxygen delivery in the elderly is also improved by the fact that regular exercise in this group seems to increase capillary density in skeletal muscle (Parizkova et al, 1971). Finally, experiments by Young et al (1983) on rats indicates that the improved ability to deliver oxygen to skeletal muscle elicited by exercise is matched by an improved ability of the muscle cells to utilize oxygen for the production of energy.

INTERACTIVE EFFECTS OF AGE AND EXERCISE ON MAXIMAL OXYGEN CONSUMPTION: From the discussion so far it can be predicted that aging will decrease and exercise will increase maximal oxygen consumption. A natural question arising from this observation is: Will the latter offset the former? That is, can the decrease in maximal oxygen consumption that accompanies aging be prevented by a lifestyle that includes regular exercise? To answer this question we must first know how much maximal oxygen consumption decreases as a function of age in a sedentary population. The problem is that accurate information of this nature has never been collected and probably never will be since to get such data maximum oxygen consumption would have to be measured periodically throughout the adult lifespan of a group of homogeneous individuals who all remained healthy and who all maintained the same level of physical activity. At present our best guesstimate based on data from cross-sectional studies of large numbers of the population is that between 45 and 75 years of age maximal oxygen consumption decreases from about 38 ml/min/kg of body weight to about 26 ml/min/kg; ie, a 32 percent reduction (Dehn and Bruce, 1972). Longitudinal studies of fewer individuals taken over much shorter periods of time indicate that this figure is very conservative (McDonough et al, 1970).

Now for the second of the two questions above, can regular exercise retard the age related decrease in maximal oxygen consumption. In one of the better studies thus far to address this issue, Pollock et al (1982) followed 45 to 65 year old masters athletes who maintained a relatively high level of training for a 10 year period. First of all the 45 year old athletes in their study had a maximal oxygen consumption of about 55 ml/min/kg, a value somewhat higher than that of a 20 year old sedentary person (Dehn and Bruce, 1972). At the end of the 10 year follow up period, when the 65 year olds were 75, Pollock's group found only a 6 percent decrease in maximal oxygen consumption between ages 45 and 75. Two bits of rather startling information come from this study: 1) an active 45 year old can have the same, or even better, physical work capacity as a sedentary 20 year old; and 2) that from the approximate 32 percent decrease in maximal oxygen consumption that occurs between 45 and 75 years of age only 6 percent can be attributed to age alone. Furthermore, at this point we are not sure that even that 6 percent is really due to aging per-se.

The obvious criticism of the Pollock study discussed above is that champion masters athletes who exercise at very high levels of intensity were used. Where does that leave the rest of us mortals who have other things to do besides spend hours a day at exercise? In answer to this question Kasch and Wallace (1976) followed a group of 45 year old 15 mile per week joggers over a 10 year period and found no change in maximal oxygen consumption. Thus, even for us mortals the decrease in maximal oxygen consumption that attends the aging process in sedentary individuals can be offset by a few hours a week of regular exercise.

SUMMARY: The maximal amount of oxygen that an individual can consume during heavy exercise is considered to be one of the best indicators of a person's potential for physical activity. In the general population this variable decreases with age. In discussing the determinants of maximal oxygen consumption and how these determinants are affected by regular habitual exercise this paper pointed out that the aging person can maintain his or her maximal oxygen consumption, and hence ability to do physical work, by engaging in exercise on a regular basis. A suggested exercise program is given in Appendix I of this paper.

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APPENDIX I

AN EXERCISE PROGRAM FOR GENERAL FITNESS

WHAT TO DO — AEROBIC ACTIVITY: walk, golf, jog, swim, bike, etc.

HOW OFTEN — 3 SESSIONS PER WEEK

HOW LONG AND HOW HARD

I. BASED ON HEART RATE: — At least 20 minutes/day
Heart rate (180 - Age)± 10

Example: If you are 60 years old your ideal exercise heart rate is: 180-60 = 120 beats per minute. The range for effectiveness is: 110 to 130 beats per minute.

II. BASED ON CALORIES USED:

		MINUTES PER SESSION	
ACTIVITY	CALORIES/Min.	MINIMAL	MAXIMAL
WALKING SLOW (Golf)	4	25	100
WALKING BRISK	6	17	66
SWIMMING	7	14	58
BICYCLING	8	13	50
JOGGING	10	10	40
RACKET BALL SPORTS	10	10	40
GARDENING	6	17	66

The above activities will use between 100 (minimal) to 400 (maximal) calories per session. Below 100 calories per session there is very little benefit to the body. Between 100 and 400 calories per session will yield considerable benefits. Beyond 400 calories per session little ADDITIONAL benefits will occcur

PLENARY SESSION

NATIONAL RESEARCH PRIORITIES IN AGING

GENE D. COHEN, M.D.
DEPUTY DIRECTOR, NATIONAL INSTITUTE ON AGING
PUBLIC HEALTH SERVICE, NATIONAL INSTITUTES OF HEALTH

WILLIAM R. MARKESBERY, M.D.
DIRECTOR, SANDERS-BROWN CENTER ON AGING
UNIVERSITY OF KENTUCKY, AND
DIRECTOR, OHIO VALLEY APPALACHIA REGIONAL
GERIATRIC EDUCATION CENTER

Objectives:

Upon completion of this presentation participants should be able to:

1. Identify active areas of aging research relevant to the health professions and academic health centers.

2. Explore future areas of aging research to which the faculty and researchers in the health professions need to give attention.

3. Increase understanding of the regional Alzheimer's Disease Research Centers' research agenda.

4. Describe characteristics of a good researcher, a good Principal Investigator, and a good grant.

PLENARY SESSION

AGING WITH A DISABILITY

NANCY M. CREWE, Ph.D.
SCHOOL OF HEALTH EDUCATION,
COUNSELING PSYCHOLOGY AND HUMAN PERFORMANCE
MICHIGAN STATE UNIVERSITY

Objectives:

As a result of this presentation and the film, SURVIVORS, participant will be prepared to:

1. To be able to identify the critical issues faced by individuals with long-standing disabilities as they age.

2. Contrast interaction patterns between health care providers and older adults with long-standing disabilities and with older adults who have new disabilities or health problems.

PLENARY SESSION

RECENT ADVANCES IN CLINICAL STRATEGIES IN GERIATRIC EDUCATION: THE ROLE OF THE GERIATRIC NURSE IN THE ACUTE CARE SETTING

TERRY T. FULMER, Ph.D., RN, C
RESEARCH SCIENTIST, SCHOOL OF NURSING
YALE UNIVERSITY

Objectives:

Upon completion of this presentation participants should be able to:

1. Discuss current personnel demands in the clinical setting.
2. Describe common models for clinical education.
3. Analyze the unit based approach versus the hospital wide approach to geriatric nursing care.

THE ROLE OF THE GERIATRIC NURSE IN THE ACUTE CARE SETTING

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Introduction

Two confluent phenomena are currently changing the nature and structure of health care in America. The number of elderly who need health care is growing exponentially at the same time the number of vacant positions for registered nurses and allied health professionals in hospitals is increasing at such a rate that a number of tertiary care institutions have been forced to close beds and restrict services for in-patients. Nursing homes and home health care agencies are experiencing similar health personnel shortages, and perhaps to an even greater degree because they are unable to compete with hospital wages and benefits.

Aiken (1987) has reported that the proportion of vacant positions for registered nurses in hospitals doubled between September 1985 and December 1986. While she reports that the output of nurses has doubled over the past thirty years, the demand for acute in-patient care is still not being met. DRG's and finance driven health care are with us for the forseeable future.

HOSPITALIZED ELDERLY

Over 40 percent of all hospital beds nationally are occupied by the elderly and, with each passing year the acuity level of those elderly patients is intensifying (NIA, 1987). The elderly account for 25% of all prescription drugs and 30% of the annual $425 billion health care expendtiture. A recent OTA report entitled "Life Sustaining Technologies and the Elderly" (1987) describes the dramatic advances in life-sustaining medical technologies, the rapid expansion in their availability and use, and sharp increase in the number of elderly individuals who are now consumers of these technologies. The report states that there are reasons to distinguish the elderly as a special population when planning care involving high technology:

* Elderly people as a group, are at greater risk of life-threatening illness than younger people.

* Because both the prevalence and severity of chronic conditions and their associated disabilities increase in old age, elderly persons who experience a life-threatening illness are more likely than younger persons to already be in a state of compromised health and reduced functioning that negatively affects their quality of life.

* Elderly people are more likely than younger adults to be victims of a dementing illness and they have high rates of other disorders (eg: depression, drug toxicity) that may temporarily or permanently impair their ability to make health care decisions.

* Comorbidity (the coexistence of more than one disease and age-associated loss of function complicate the prognosis and treatment of life threatening conditions in elderly persons.

* There are questions about the quality of health care currently available to elderly patients. Many health professionals in practice today are poorly prepared to care for seriously ill elderly people whose presentation of disease and response to treatment may differ from that of younger people.

* As a group, elderly people utilize a large share of all health care resources and consume the largest share of public health care dollars.

* Elderly people, as the major beneficiaries of medicare, may bear the brunt of Federal efforts to contain health care costs.

* In contrast to other segments of the population, especially newborns and young children, the law recognizes the autonomy of elderly adults.

* and finally, Elderly persons are more likely than younger adults to have contemplated the meaning and value of their life and its end.

These factors are at the heart of dilemmas in hospital nursing practice related to the elderly. The elderly patient and family must confront difficult decisions and complex choices daily. Ethical issues related to such matters as abuse of guardianships and conservatorships, the allocation of scarce resources and poorly trained personnel are worrisome.

The social context and the way care delivery is organized often determines the way consumers evaluate the quality of that care. With the advent of advanced technology producing more choices and complex decisions, elderly are faced with an array of interventions which can at times create more chaos that cure.

Excellent clinical management of geriatric patients, regardless of setting, is predicated on the fact that the organization of care is logical, perceived as a continuum, and allows for excellent communication among all involved.

I agree with Maggie McClure that the profession of nursing is in the central position to provide continuity of care by acting as the integrator (McClure and Nelson, 1983) of services and the facilitator of information. The way care is integrated determines the effectiveness of the therapies. Consider the following case:

> An 87 year old woman was admitted from a nursing home to the hospital emergency unit for evaluation of right hip pain following a fall from the bedside commode. Xrays revealed a right hip fracture and the woman was prepared for the operating room. Since the event occurred after dinner at the nursing home, it was 10PM by the time she was prepared for the operating room. She went to the operating room and the surgery was completed by 1AM, next, she returned to the recovery room where she received 50mg of demerol IM every two to three hours. The recovery room was very active that evening with three other post operative cases also in the same room. All of the lights were on and there were a number of monitors and machines making the usual noises for that particular

environment. The woman intermittently would awake from her anesthesia and cry out for "Annie", her usual nurse from her nursing home where she had resided 6 years. The nurses assured her that she was at the hospital now because she had broken her hip and that they would take good care of her. This provided the woman with some comfort, however, she continued to thrash throughout the night. The recovery room nurses were hesitant to offer her more pain medication because they were afraid that a higher dose might cause a confusional state in an elderly patient or that it might "snow her". By five o'clock in the morning they returned her to the general unit and at 5:30AM the surgical team made rounds in order to be sure that her post operative course was going well. By 6:30AM, the day shift began to arrive and at 7AM the Primary Nurse came in to introduce herself as well as check the patient's vital signs and begin delivering routine morning care. The morning sped by and soon lunch activities were beginning. Immediately following lunch, the patient's family came in and said they had heard about the accident and were very concerned for their mother. They visited for the remainder of the afternoon. That evening the patient began to exhibit bizzare hallucinating behavior yelling "operator, operator". The patient was ordered for PRN Haldol/2mg, which she was given.

The preceding case really drives home the point that it is important to treat the cause of the disorder, not the behavior. This classic story entails a number of common geriatric problems which I'd like to point out for the benefit of this audience:

#1 falls

#2 medication sensitivities

#3 confusion management

#4 fragmentation of care.

*Each of these subjects could be an all day conference.

This elderly lady was in the following settings in less than a 24 hour period: the nursing home, the emergency room, the operating room, the recovery room, and the general unit. Her sleep was, to say the least, disrupted. She was assaulted by a barrage of activities, medications, procedures, and people, which led to an inability to get any useful rest. The main problem was her hip but what resulted was an iatrogenically induced confusional state which was then managed by medication.

This is an example of good intent with negative outcomes for the elderly person. An improved sensitivity to the onslaught of stimuli that can accost a person in the hospital environment is a first step toward effective clinical management.

Nursing care of the elderly in hospitals usually centers around these care issues to a much greater degree than upon the original admitting diagnosis. For example, consider the same elderly lady and now let's continue with what a possible clinical course for her care might be.
The first several days of her hospitalization really center around post operative management, pain control, and mobilization after hip surgery. In the course of that time, however, she may have episodes of incontinence which could increase in number of episodes as her hospitalization continues. (Anesthesia can also lead to an atonic bladder.) Once an elderly patient is labelled as incontinent in the nursing report, there can be a very low level of expectation regarding changing that incontinent status. Review of nursing progress notes in the patient's record will often list the number of times that the person was incontinent, but there may be little comment related to interventions to reverse the incontinence.

Similarly, because this person has had difficulty in sleeping, an order for Dalmane or some other potentially dangerous hypnotic sedative may be obtained by the nursing staff and administered with its resultant

deleterious side effects. If there is a confusional state that results from hospitalization, one of the most usual approaches is treating the behavior instead of understanding the reason for the behavior. Confusion management may include the use of restraints (both physical and chemical) which may then impede an elderly person's ability to feed himself, get to the bathroom or help with his care. If there is a shortage of nursing staff on a given unit, it may mean that the elderly person has less than adequate time to be fed or to be aided in eating which can lead to dehydration and weight loss. When the elderly person struggles to get the restraint off, he may try to climb over the bedside rails on his way to the bathroom, slip, fall, and break his other hip. By this time it may be that the nursing home bed is no longer available and the elderly individual is now what we term a "placement problem". This person is probably costing the hospital system a lot of money if the Utilization Review Committee decertifies the bed and the nursing staff may begin to have a decreased sensitivity to the care needs of this person because the orthopedic surgeon's progress note says "stable". I submit to you that this individual is not stable.

Clinical management of the elderly patient has become a sub specialty which can no longer be thought of as merely an extension of medical-surgical nursing or adult medicine. The preceding case highlights the sensitivity required to give the best care possible to older individuals. The fact that more than 40% of hospital beds in the United States are occupied by elderly individuals and over 65% of all nurses in our country are employed in hospitals means that it is increasingly evident that all nurses will need more and more knowledge related to effective care of the elderly. (Fulmer, Ashley, Reilly, 1986). At the same time, while only seven percent of the elderly reside in nursing homes, it is expected that soon after the turn of the century, that percent may double. (U.S. Senate, 1987).

In the United States, nurses who have a special interest in geriatric nursing may choose to enroll in a Master's Program in Gerontological Nursing in order to learn the knowledge base they need to effect change in their system for better care of old people. While I agree with this approach as a sound one for advanced practice, I'd like to suggest that a successful hospital course for the patient begins with each and every primary nurse and we need to provide a program for such development. A unit based Gerontological Resource Nurse program is one approach to improve practice. By Geriatric Resource Nurse I am referring to an individual who is willing to be accountable for an advanced level of knowledge related to caring for the geriatric patient and share it with her peers. At the Yale New Haven Hospital in New Haven, CT, we are in the process of refining this model for the units in the hospital (first at Beth Israel Hospital). The goal is that, on every unit, a nurse is identified as a person who has a high level of interest in the geriatric patient and is willing to serve as a resource for information. She uses the geriatric clinical specialist as her support for questions that she may not be able to answer but in general she is recognized as the resource. Her constant presence on the unit is a reminder to the individuals that there is a special approach to clinical geriatric nursing. Routines that may be effective for middle aged adults are not necessarily effective for the elderly. McClure (1982) reminds us that nursing care is the main reason for in patient facilities of any type and in relation to geriatric care it's likely that the nursing challenge will continue to be extensive given the complexity and array of nursing care needs. Effective clinical management means that there is an integration of activities and services that enhance health, prevent exhaustion, confusion, and patient stress.

In addition to the admitting diagnosis of a fractured hip, an older patient may have a hearing or vision impairment, decreased mental acuity, previous ambulation problems, loss of skin integrity, and a lack of self care skills, such as feeding, toileting, and dressing, all which may exacerbate the primary condition. Clearly, without careful clinical management, the older adult may receive fragmented care which can prove injurious rather therapeutic.

I believe the development of Geriatric Resource Nurse programs can serve to facilitate the following goals:

1) an increased sensitivity to the needs of geriatric patients;
2) an improvement in the practice of geriatric nursing;
3) a critical mass of clinicians who can work together to formulate an appropriate program of nursing research for the elderly;
4) and finally, a recognition of this field as one that requires intensive research in order to provide improved care.

For the purpose of this presentation, I am using the hospital as an example for how such a program might be developed. However, there is no reason why long-term care facilities cannot use a similiar model. Home care agencies would benefit from identifying several clinicians who prefer geriatric care and can become expert in it. I view this as a stepwise progression. Once the Geriatric Resource Nurses are identified, over time they should be developed to a next level which is that of expert on some given topic they are particularly interested in. For example, on an orthopedic unit, it may be the Geriatric Resource Nurse who notices that several of the patients who were continent when admitted become incontinent during hospitalization. With the staff she could develop a protocol for evaluating this problem on her unit and make a difference in the clinical management of incontinence with an emphasis on prevention and rehabilitation. This is much more

useful than merely documenting the number of times and individual is wet in any 24 hour period.

Primary nursing allows for comprehensive, coordinated, patient-centered care. It encourages the nurse to use all intellectual and creative resources and skills to formulate and implement the most appropriate and personalized nursing plan for a particular patient. The benefits for elderly patients are realized through the continuity and individuality that is offered in this type of model. While physical needs are attended to, the support that is offered by the nurse for the elder who can be faced with difficult decisions regarding treatment or discharge planning can be invaluable. Lifelong habits and routines of the elder can be evaluated in the context of the overall the health and well-being of that older person. Other professionals respond positively to such models because they know that there is an individual who is accepting responsibility in a comprehensive way for the clinical management plan developed by the interdisciplinary team.

Within this context, let us now reconsider the clinical management of the case presented with an emphasis on the problems identified.

Falls Prevention

Frail elderly patients in nursing homes are high risk for falls.

Since all people lose bone with age, fracture can occur spontaneously or with minimal trauma. (Pilbeam and Resnick, 1988). The best approach is prevention and elders should be offered assistance to the commode when they are frail, unsteady, or even just tired. Commodes need to be carefully secured to ensure they don't move as the elder attempts to get on or off. Floor space surrounding the commode should be clear and toilet paper should be within easy reach. Obviously, the nurse call-light should be easily

accessible. Patients who are high risk for falls should be identified by some routine method, such as a warning decal in their chart to remind the staff that special precautions should be taken. Jackson has reported that the following variables are predictive of falls: (Jackson, 1988)

1) age related changes in blood pressure with postural changes
2) an increased number of chronic diseases
3) low morale
4) impaired sensorium
5) antidepressants, phenothiazines or sleep medication
6) environmental hazards

Careful attention to these predictors should decrease the number of falls that occur.

Medication Sensitivities

The clinical management of medications in the elderly is a delicate balance. Age related changes in pharmacokinetics alter the absorption, metabolism, distribution and excretion of drugs. As evidenced by this case, it is important to keep in mind the total therapeutic plan when prescribing new drugs or altering dosages. We need to teach our medical students to "start low and go slow" as they prescribe drug dosages. The elderly are frequently taking three to five medications regularly for chronic disorders. When an acute event occurs such as this lady's hip fracture, anesthesia and pain medications can interact negatively with drugs currently prescribed.

A drug history is important because certain drugs may cause peri-operative complications. A patient on chronic benzodiazapine therapy for example may exhibit withdrawal symptoms, while diuretic induced hypokalemias may yield arrhythmias during surgical stress. Sleep deprivation may induce bizarre behavior which is then worsened by added medications. Delirium

occurs very commonly and most studies suggest the post-operative incidence is about 25 percent in elderly (Meneilly, etal, 1988). A pre-operative mental status examination is helpful to assess the degree of confusion.

Confusion Management

Acute confusional states (delirium) are frequent in the hospital setting and may be one of the first signs of illness. Senile dementia (a progressive decline in cognitive function) is the more chronic state. What often happens is that an elderly person with a baseline dementia becomes acutely confused and the acute state is ignored or misdiagnosed due to the dementia labelin the cardex. In order to effectively manage a confusional state, a baseline mental status is needed in order to determine the therapeutic plan. Safety is the first and foremost issue for both the patient and the. Acute confusional states are frightening for everyone involved and it is important to gain control of the situation before an accident occurs. The nurse should remain calm and avoid lunging at the patient, restraining him unnecessarily or medicating before an assessment is completed, and the necessity proven. Calm behavior may be the only action needed. If the patient is in danger of harm to himself or others, the least restrictive method of restraint should be employed or a low dose of an appropriate drug. It may be that sleep alone can reverse the problem.

Fragmentation of Care

The fragementation of care is an issue within and across settings. The array of health services needed by the elderly is complex and difficult to coordinate. A primary nursing system along with an excellent documentation system can help alleviate the problem in the hospital setting. The case management approach is very popular for elders who meed more intensive support.

While few hospital nurses would consider themselves geriatric nurses, those same nurses are being called upon to provide the specialized care necessary to help the elderly prepare for discharge to an appropriate setting. Those individuals who are over 85 years of age will double from 2.7 million to over 5 million by the end of this century. Clearly, the demands on acute care nurses will overcome the sources unless creative strategies can be implemented which support those nurses as they provide care for the elderly.

QA (Quality Assurance) measures which reflect the physical and psychological well being of elders can be prospectively identified and followed over time as a way of monitoring patterns among elderly patients and the potential impact of the unit based resource nurse. Such areas as

* confusional states
* fractures
* decubitus ulcers
* dehydration
* falls
* incontinence
* infection
* malnutrition
* constipation

These are commonly agreed upon as serious clinical conditions which place elders in potentially life threatening states. Much needs to be done to prevent these events or at least reverse them once in progress. Programs of research in these areas are still relatively young and replication studies are needed.

What then can be viewed as the potential benefits to elderly patients on units with GRN's?

Benefits to the Resource Nurse

The resource nurse benefits from assuming the position in that she is provided an opportunity to expand her knowledge base with appropriate supports and can feel a sense of achievement over time as the quality of geriatric nursing care on her unit improves. Her willingness to act as a resource nurse should be interpreted as leadership behavior and should count in relation to the clinical ladder programs which are now fairly common in nursing services. This type of activity also provides the nurse with the opportunity to explore an area of interest before committing to graduate school. Conversely, a role like this can be viewed by collegiate admissions committees as noteworthy during the student selection process. The increase in workload can be offset by preferred scheduling, library days, and other such activities.

SUMMARY

In conclusion, hospitalized elderly require knowledgable nurses who can provide a comprehensive approach. The Geriatric Resource Nurse Program can have a positive impact and help hospital nurses focus on the special needs of the elderly.

The field of geriatrics is changing rapidly as new research yields new information regarding optimal care. As we approach the next century, we need to bring with us strategies that will provide for the safety and comfort our elderly family and friends deserve.

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PLENARY SESSION

INTERDISCIPLINARY GERIATRIC EDUCATION: IMPLICATIONS FOR EDUCATORS

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Objectives:

Upon completion of this presentation participants should be able to:

1. Identify institutional and professional barriers to interdisciplinary geriatric education.

2. List and discuss at least four justifications for interdisciplinary geriatric education.

3. Implement at least three program development strategies directed toward initiating an interdisciplinary geriatric educational program.

Interdisciplinary Geriatric Education: Implications for Educators

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The demographic imperative for geriatric training and care is well documented and comes as no surprise to those of us in the field (for a recent manpower update see U.S. Dept. of Health and Human Services report to congress, Sept. 1987). The dramatic increase in the numbers of elderly, particularly those age 75+, suggest that geriatric health care will grow in importance throughout the next decade. The purpose of this paper is to briefly examine models of geriatric education which may have relevance for attempts to formalize and institutionalize geriatric content in academic institutions and to suggest strategies for implementation.

The domains of geriatrics and gerontology have continued to overlap as models of training and health care delivery have evolved. Distincitons between these two perspectives remain important, particularly as they pertain to the emphasis on training related to normal vs pathological aging. However for purposes of parsimony the term geriatric will be used in a broad context which would include gerontological education as well. The reality of our educational experiences suggests that a balance

between normal and pathological aging content in our curriculum is one of the first crucial variables to be addressed.

The Evolution of Geriatric Education in the Health Care Disciplines

Typically program development in geriatric education has begun with an assessment of what currently is taught in a specific health care curriculum and a focus on how and when the material is introduced into the course of training. At this point it becomes possible to review what is currently being taught and to compare it to what current research data and practice concepts in the field have to contribute in order top establish a core knowledge base in geriatrics within a given discipline. Eventually this process leads to the development of an "identity" for geriatrics within a given institution or discipline and will frequently generate a set of uniform guidelines for the content and format of the curriculum. Allopathic and Osteopathic Medicine, Nursing, Psychology, Occupational Therapy and Social Work for example have all produced national curriculum guidelines related to geriatric training. These guidelines have served to stimulate revisions in existing curricula and the development of new geriatric training programs as well. (See Hubbard and Santos 1989)

In clinically oriented disciplines faculty and practioners working together will identify a core set of knowledge pertaining to the discipline and discuss how it should be disseminated to students. In fact, one of the positive outcomes of geriatric curriculum development is that it offers the opportunity for bringing the academic institution into closer contact with community practioners many of whom are graduates of the institution.

In some cases additional attention has been given to the degree of training required for specialization and/or certification in geriatrics, in

others, geriatrics has been adopted as a core area of training for all students. During the early stages of "identity" development geriatrics has often been seen as an elective rather than required area of training generally occurring at the senior year or post graduate level. While this approach does contribute significantly to identity formation it also tends to isolate content and may encourage students and faculty to perceive it as a special topic rather than as a segment of the core knowledge base in their profession. As a point of comparison what psychology major doesn't require child development as a course? An examination of the degree and type of clinical contact the professionals in the discipline currently have and a consideration of future patient population trends can help to determine which approach is more advisable. It is notable that as the numbers and needs of Older Americans has continued to grow an increasing number of disciplines have concentrated their efforts on mainstreaming geriatrics into the core curriculum all students participate in.

Close scrutiny of current course offerings and topics will typically facilitate the "greening" of existing courses with additional geriatric content, for instance a course on pharmacy might be expanded to include geriatric pharmacologic content, or an interviewing practicum might include an emphasis on special issues in interviewing older patients other courses might have their coverage extended to include lectures on age related chronic diseases. The essential task with this approach has been to work within existing curricular strengths in an attempt to mainstream geriatrics into current core courses.

When time and schedule flexibility permit many disciplines have extended their curriculum through the development of a core course in geriatrics which provides an overview of interdisciplinary issues in the field and sets the stage for further study in other courses and on an

elective or post graduate level. This strategy elevates the field in terms of it's prominence in professional education and assures the discipline that all it's graduates will at a minimum be exposed to some of the fundamentals of geriatric care. This may be a particularly fruitful approach in schools with strong Allied Health Professions training where courses in each department may be duplicative and costly while an interdepartmental core course in geriatrics and gerontology might set the stage for later specialization within each department.

Without exception health care training involves clinical experiences for students and as a result these components need to be examined in the light of increasing geriatric emphasis within a curriculum. The expansion of sites to include long term care facilities, interdisciplinary assessment centers and community/home based services for the elderly is typical in this area. Obviously this will lead to a significant increase in clinical faculty as well. The timing of clinical experiences is critical to successful training. Sending students to nursing homes after or during an introductory course can have disastorous results. Faculty need to devote careful consideration to the amount of training students need prior to clinical exposure and to the type of clinical setting and the amount of supervision to be involved. Since the majority of older adults are in fact relatively happy and healthy perhaps more of our disciplines need to consider an early experience with the well elderly for our students. Exercises involving the life review, a cohort-historical interview and others can be very useful in this regard.

The degree of research training and experience health care students receive in the various disciplines varies widely. It is important to note that as geriatric curriculum has been revised and implemented opportunities for research experience have also increased. The number of

Master's Theses and Doctoral Dissertations in Gerontology and Geriatrics continues to rise. Disciplines which emphasize research or researcher-practioner models may need to include a core course in geriatric research methods which might also cut across disciplines and departments.

The evolution of geriatric education in health care disciplines has in some cases been tied to an examination of professional identities as well. Geriatrics may bring the health care professional into new clinical settings such as home health care or extended care facilities where their roles may need to be redefined. The increased demand for care on the part of older patients may also require some disciplines to consider more independent models of practice.

Having considered a brief historical framework for the development of geriatric curricula this paper will now move to an examination of critical issues which need to be addressed by faculty preparing to embark on geriatric education and program development.

Critical Questions in Geriatric Curriculum Building

There are a number of fundamental questions which faculty and institutions must address in planning curriculum development in geriatrics. The answers to these questions will set the tone, identity and ultimately the goals of the course that is chosen. Some of the more salient questions are listed below with a discussion of some of the variables which merit consideration.

How do we move beyond the Introductory Level ?

There is a potentially dangerous pattern forming in many institutions and perhaps in continuing education programs as well in which the sole or major enterprise is to expose the unwashed to basic introductory concepts in gerontology and geriatrics. Thus we concentrate on overviews,

introductory courses and generalist lectures which typically begin with the phrase "By the year 2000....". We certainly have ample evidence that there are large numbers of practioners working with the elderly who need such introductory level experiences.. However to devote ourselves primarily or exclusively to this task is to enter the geriatric education with a short sighted emphasis on introduction and little or no formal plans for production of thoroughly trained professionals.

Traditionally education involves having an impact on the participant's knowledge, attitudes and skills. We must be more than cheerleaders, exhorting students and professionals to care for and about the elderly ,we must also provide our students with a diverse array of opportunities for skill development and knowledge enhancement as well as experiential learning which may impact more heavily on attitudes. In other words, although small intensive training experiences involving supervised clinical activities may be burdensome, whenever possible, they need to be in place and actively marketed to students.

In some cases universities have arrived at an initial level of curriculum development; introductory courses are in place. However, advanced seminars, clinical experience, research opportunities and other educational opportunities designed to produce geriatric professionals rather than introduce or sensitize student to the problems of the elderly, are lacking.

Why Interdisciplinary Geriatric Education?

Perhaps the most frequent shift which occurs when disciplines consider geriatric training and care is the recognition of the utility of applying interdisciplinary service delivery models to the multiple and interactive problems which the elderly patient frequently presents. Geriatrics is developing in a very dynamic care environment, hospitals have recognized

the emerging market changes, health care disciplines have identified manpower shortages and are beginning to make attempts to close the gap between geriatric health care needs and the available professionals to meet those needs. Beyond these systemic changes the most compelling force behind the interdisciplinary models which are beginning to be the predominant mode of geriatric service delivery are the multiple, interactive myriad of bio-psycho-social problems the elderly patient confronts us with. The interdisciplinary geriatric movement began in clinical settings and has gradually moved into education where tomorrow's health care professionals are being prepared to encounter interdisciplinary assessment, treatment plans and team roles. Health care training in this regard tends to incorporate knowledge related to professional development and roles with core knowledge bases from disciplines perceived as being most likely to interact regarding patient care in a health team context. This might involve consideration of geriatrics as it relates to disciplines such as physical therapy, speech and communication disorders, social work, nursing and specialties within medicine. Courses related to health care team functioning and roles as well as clinical experiences in such settings are equally important in training.

At issue here is a fundamental recognition that geriatric education is and will continue to be an interdisciplinary enterprise. This does not require a complete abandonment of traditional modes of teaching or practice. It does however mean that when it is efficient and possible given faculty resources, faculty need to consider team teaching involving more than one discipline and attempts at multidisciplinary offerings at the very least. More fully interdisciplinary training attempts will encounter difficulty in merging with the traditional disciplinary boundaries of

academia, however curriculum modules are being developed (Hubbard and Santos 1989) and as the pool of geriatric faculty resource persons grows in numbers and disciplines opportunities for cross discipline collaboration in teaching should increase.

Do We Need to Offer Certificates or Degress in Geriatrics ?

This issue has been particularly strong in gerontology programs and has led to a great deal of healthy discussion and controversy regarding the merits of such approaches and the degree to which gerontology is or isn't a discipline in and of itself and how marketable a degree or certificate is in the work place.

Developing a specialty in geriatrics does provide opportunities for more in depth training and may lead to the development of credentialing standards which may gain recognition by other disciplines. However it may also exclude current practioners and and discourage students who feel that training requirements are already rigorous enough. Perhaps more importantly, movement toward certification of a relatively small number of health care professionals may not accurately reflect the practice reality in a discipline's clinical world in which older adults may represent a sizeable portion of the typical practioner's case load. In this case superimposing a geriatric curriculum on the existing core training that each professional receives may be more appropriate.

Do We Need Faculty Development ?

Every discipline that has considered enhancing it's geriatric training has also considered faculty development programs designed to update and increase the knowledge of faculty members delivering the training. In some cases this has resulted in the identification of a small number of individuals who have already received some training and/or experience in the field. These individuals have received release time to further develop

their skills and are appointed to leadership positions in geriatrics. The Federal Government is currently funding over 30 Geriatric Education Centers through the Bureau of Health Professions, these centers are mandated to provide interdisciplinary faculty development through a variety of flexible training formats and are therefore ideal training sites for this type of professional education. In other cases faculty wide training has been accomplished through seminars, continuing education programs and lecture series, again Geriatric Education Centers can be utilized as resources. (Hubbard and Santos 1989)

Enhancing Geriatric Curriculum: A Strategic Model

A review of the evolution of geriatric training in health care disciplines reveals a number of lessons learned and tasks to be accomplished. Once a working committee of faculty and administration has been established a number of tasks need to be accomplished. First, it is important to assess the current and future geriatric health care demands within each discipline. Manpower projections, current clinical activity and a historical perspective on the prior development of geriatric care within the relevant disciplines at the institution should be included.

Second, the committee should consider conducting a survey within the institution regarding the current amount and level of geriatric training offered, faculty interest and expertise and student attitudes and interest. Include clinical training sites and current or potential clinical faculty in the survey. The survey data should be analyzed in terms of gaps in the curriculum, need for faculty development and the next logical progression in geriatric curriculum building. It is important to keep in mind that expressing interest is different from indicating expertise, interested faculty may still need training. This can also be an important time to study models at other universities.

Third, Once these tasks have been accomplished it will be possible to develop a plan for the development and institution wide endorsement of strategies for faculty development, curriculum development and enhancement of geriatric clinical training sites. Seeking consultation from other disciplines regarding interdisciplinary content and the examination of the impact of geriatrics and interdisciplinary clinical models on your professional roles and identity in health care frequently occur at this level of development.

Fourth, the committee needs to establish a set of guidelines for the institutions to follow in geriatric program development. The guidelines should include specific recommendations for the minimum number of classroom and clinical hours which should be devoted to geriatric training as well as suggestions on how the training should be integrated with core courses and electives already available. The guidelines should attempt to delineate the topic areas which the training should encompass along with clinical site recommendations.

Finally, a time line for the implementation of the various phases of the plan and develop mechanisms for monitoring progress and evaluating outcomes should be put in place.

Summary

The challenge is clear, develop geriatric training and programs now, establishing your institution as a leader in the movement or wait a few short years until changes in health care training force you to be a follower. Carve out your own geriatric niche or be prepared to have some other entity thrust one upon you.

The further development of geriatric education can serve as a spring board to a broader base of services, greater interdisciplinary contact and renewed interest in professional development. The lessons from other

disciplines are clear: building a coalition of educators and practioners committed to promoting geriatrics in the classroom and clinical setting can lead to an important impact on administrators, policies , plans and ultimately the quality of care for Older Americans.

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II.

RESEARCH STUDIES IN AGING: PART 1

Objectives:

Upon completion of this presentation participants should be able to:

1. List the benefits associated with use of a curved-bristle toothbrush designed for assisted brushing.
2. Identify the components of a nutritional assessment tool which can be utilized in nursing homes.
3. Identify the extent and characteristics of anorexia in the elderly as determined through a review of medical charts.
4. Describe the incidence of accidents among the elderly relative to theories and processes of aging.

Authors:	Topic:
Richard L. Meckstroth, DDS West Virginia University	The Curved-Bristle Toothbrush: Designed for Assisted Brushing
*Nancy D. Stephens, RD, MS Roberta Messner, RN, C, MSN, CIC Huntington VA Medical Center Kevin Conaway Shirley M. Neitch, M.D. Marshall University School of Medicine	Evaluation of Nutritional Status of Nursing Home Residents
Betty J. Bartlett, RD, MS The Ohio State University	Characterization of Anorexia in Nursing Home Patients
*Donald L. Thompson, Ph.D. Martha A. Coleman, RN, Ed.D. Georgia Southern College	Accidents, the Elderly and "The Golden Years"

*Denotes Presenter

TITLE: THE CURVED BRISTLE TOOTHBRUSH: DESIGNED FOR ASSISTED BRUSHING

Author: Richard L. Meckstroth, D.D.S.
Institution: West Virginia University School of Dentistry

Introduction

A large percentage of the residents in long-term care facilities are unable to achieve an acceptable level of oral hygiene due to mental and physical incapacities and, thus, need to rely on nursing staff for daily oral care.

This study was set up to evaluate a toothbrush specifically designed for the dependent resident who needs assistance from an attendant in brushing. The goals of this study were to further evaluate the Collis Curve Toothbrush in relation to efficiency of plaque removal and to attitudes of the nursing staff using it for dependent residents.

Materials and Methods

This study involved 22 geriatric residents, who volunteered and had a minimum of one arch of natural dentition (uppers or lowers). Six specified teeth, one from each quadrant of the mouth, were examined in each resident. An erythrosin disclosing solution was applied with a cotton tip applicator to the lingual and buccal or facial surfaces. A score of 0 to 3 was given for a total of twelve scores per resident per visit.

The study was conducted over a five-week period. The first week was used to introduce the nursing staff to the curved bristle toothbrush and its method of brushing. On the first day of the second week, a baseline score was taken and the residents were introduced to the curved bristle brush. During the week, four plaque scores were recorded after using the curved bristle brush. On four days during the third week, the plaque score was recorded after using a straight bristle brush. During the fourth and fifth weeks, the nursing staff continued to brush using the brush of their choosing. At the end of the five weeks, a follow-up score was recorded.

In addition to the plaque scores compiled from the residents, a questionnaire was given to 48 nursing staff to get an indication of their response to the curved bristle brush as compared to a straight bristle brush. The questionnaire was given at the end of the third week after they had a chance to compare both brushes and again at the end of the study to see which brush was being used, and to see if their attitudes had changed.

Results

The difference between plaque scores recorded for the two brushes were not statistically significant. Although the curved bristle brush provided lower plaque scores than the straight bristle brush in all areas, except the maxillary and mandibular facial. The lingual surfaces recorded the greatest differences, especially the posterior lingual.

The most significant aspect of the study was the responses by the nursing staff. On the first questionnaires, 95% said the curved bristle brush was easy to place on the teeth. That response increased to 100% on the second survey.

As to the ease of manipulation, 76% felt the curved bristle brush was easier to manipulate, 2% felt the straight bristle brush easier and 22% responded they were about the same. In the follow-up questionnaire, 90% felt the curved bristle brush easier and 10% felt them to be about the same.

Question three was asked to obtain the nursing staff's subjective feeling, as to time needed for oral hygiene. On the first survey, 76% felt the curved bristle brush took less time, 5% felt the straight bristle brush took less time, and 19% felt them to be about the same. On the second questionnaire, 85% felt the curved bristle brush took less time and 15% felt them to be about the same.

Regarding nursing assessment of resident complaints during brushing 67% noted fewer complaints with the curved bristle brush, 8% fewer complaints with the straight bristle brush, and 25% felt the response equivalent. By the end of the study, 90% felt they received as many complaints with one brush as they did with the other, and 10% felt the curved bristle brush received fewer complaints.

Regarding ease of brushing residents' teeth, the first survey showed 73% felt the curved bristle brush made the job of oral hygiene easier, while 27% felt the brushes to be about the same. At the end of the study, 42% felt the curved bristle brush made the job easier and 58% felt the brushes to be about the same.

Discussion

The greatest difference in scores for the two brushes were on the lingual surface of the posterior teeth. For the straight bristle brush to clean this area, it must be placed where it infringes upon the tongue. Since the curved bristle brush, if properly used, does not infringe upon the tongue space, this may explain why the nursing staff felt they had fewer complaints with the curved bristle brush.

As mentioned earlier, the maxillary and mandibular facial areas had lower plaque scores with the straight bristle brush. After this observation, brushing instructions with the curved bristle brush were modified. After the brush was used as designed (clamped over the teeth), the curved portion was used the way a straight bristle brush would be used for the facial surface of the anterior teeth. With this simple modification, the curved bristle brush performed as well as the straight bristle brush on the facial surfaces.

The follow-up mean plaque score was not as good as during the study, but better than the baseline score. This difference of 0.568 (an improvement) in the mean plaque score, over baseline, may be due to the use of the curved bristle brush. A decline in mean plaque score of 0.455, from the score during the study, could be due to not monitoring the brushing procedure prior to the follow-up score being taken.

The importance of proper oral hygiene has to be supported by nursing supervisors and monitored from time to time. More frequent inservices on the importance of dental health and oral hygiene, for both residents and staff, may improve self-motivation in performing oral hygiene procedures.

A professional prophylaxis prior to this study would have benefited every resident in the study and probably would have improved the plaque scores for both brushes. As long as a resident has teeth, whether natural or artificial, he or she will benefit from regular professional oral exams and prophylaxis. Poor oral health can be a major contributing factor to malnutrition, decreased vitality, facial disfigurement, and embarrassing social encounters. By setting mutual goals, the nursing supervisor and dentist can raise the level of health care.

The prevention of additional and complicating illness can be enhanced with effective oral health practices, making the jobs of the staff, supervisors, administration, and other health professionals more enjoyable and rewarding.

The last point of discussion will be to compare the first three questions on the questionnaire with the last two. When looking at the first three questions, it is easy to see the vast majority felt the curved bristle brush was easy to place on the teeth, easy to manipulate within the mouth and felt it took less time to do the job. When looking at the last two questions, initially, the majority felt they received fewer complaints with the curved bristle brush and felt that it made the job easier. By the end of the study, they felt they were receiving as many complaints with one brush as the other, and those who thought the curved bristle brush made the job easier had fallen from 73% to 42%, with the others feeling the brushes to be about the same with regard to ease of use.

Acceptable plaque removal is difficult, so when 42% respond that the curved bristle brush makes their job easier, that seems clinically significant. Another percentage that may be significant is the 67% who felt they received fewer complaints with the curved bristle brush. The fact that on the second questionnaire it was reported as many complaints were received with one brush as the other may be the result of attempts to get more attention through complaints. The residents were not informed as to which brush was being used. Therefore, the response from the first questionnaire, prior to the novelty of the study fading, may be the best indicator of the residents' feelings about the different brushes.

Conclusion

The curved bristle brush was well accepted and made the task of oral hygiene easier for the nursing staff. As for plaque removal, the curved bristle brush removed more plaque than the straight bristle brush. Regardless of the brush used, monitoring of oral hygiene procedures significantly improved plaque scores.

The curved bristle brush was also well received by the residents. This was probably due to the fact proper brushing could occur without the brush infringing upon the area of the tongue or cheeks.

The results of this study suggest that the curved bristle brush may be the recommended oral physiotherapy aid for the individual needing assistance with brushing. Institutions need to consider adoption of this toothbrush as a way to make the oral hygiene task easier for their nursing staff.

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TITLE: "Evaluation of Nutritional Status of Nursing Home Residents"
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Introduction

In 1974, Butterworth's now classic article alerted us to the "Skeleton in the Hospital Closet," and since that time malnutrition among hospitalized patients has been increasingly given the attention it deserves, both in clinical practice and in research. During this same period of time, the rapid aging of the population has brought to the forefront the importance of nutrition in the geriatric age group. Nursing homes and other long-term care facilities continue to increase in number, and nutrition should be a vitally important concern in such facilities. Unfortunately, clearly established and widely accepted nutritional assessment guidelines for elderly person do not yet exist. Consequently the nutritional status of patients entering nursing homes is addressed in a haphazard manner, if at all.

This two-part project was initiated to first, assess whether nutritional parameters are ordered and properly interpreted on vewly admitted patients, and whether the diagnosis is actually documented so that vigorous intervention can be instituted; and secondly, to determine the incidence of malnutrition in our nursing home population. These questions have been addressed only briefly in the literature to date.

Methods:

The first part of the study was a retrospective chart audit of admission data of patients in four Huntington, WV area nursing homes. Two facilities surveyed are corporate owned and are 60-bed, rural, intermediate nursing facilities; while the other two are urban, skilled nursing facilities, one corporate (60-beds) and one privately owned (180-beds). All residents in the facilities in June and July of 1987 were surveyed, except in the largest facility, where, due to patient census at the time of the survey, one-half the patients on two floors were randomly surveyed.

In total, 251 charts were reviewed. 19 were excluded because of age, leaving 232 patients 65 years old or older in the study. Data was collected from doctor's notes and orders, nurses' notes, dietary notes, and laboratory reports. Only values documented within 10 days before or after admission were considered to be reflective of the patients' status at the time of admission. Data collected for part one of the study included age, sex, race, admission diagnoses, significant history and medications, weight, height, serum albumin, total lymphocyte count, and hemoglobin.

In a follow-up study, (Part 2) 50 residents of one of the facilities were re-surveyed with a standardized nutritional evaluation instrument to determine actual prevalence of identifiable malnutrition. Results of both studies will be presented.

Results:

Table 1 indicates how often the four nutritional parameters (wt/ht, serum albumin, total lymphocyte count, and hemoglobin) had been documented within the 10 days before or after admission to the nursing home. Hemoglobin was recorded most often (on 63.5% of charts); followed by weight (59.9%), TLC (57.8%), and albumin (46.1%).

Three of 232 charts reviewed (1.3%) listed a diagnosis of malnutrition. Two of these patients had values documented for three parameters and all three were abnormal. The third patient carrying the diagnosis of malnutrition had been evaluated with all four parameters, and two were abnormal. Of the four patients with four of four parameters abnormal, none had the diagnosis listed.

Discussion:

This study demonstrates both the theoretical and the practical difficulties inherent in nutritional evaluation of the elderly. The first problem encountered is the choice of physiologic parameters for measurement of nutritional status in the elderly. In spite of considerable recent research, widely accepted standards are still lacking. Many authors have published conflicting findings on the usefulness of serum proteins, hematologic values, and various anthropomorphic measurements as nutritional assessment tools in the elderly population.

Serum proteins have long been known to be directly related to nutrition, and many of the most careful studies have used transferrin as the serum protein most indicative of nutritional status. while in a research setting this may be ideal, practically speaking it is virtually impossible to use because it is not a "screening" test, but only ordered by physicians investigating specific hematologic problems. We chose to use serum albumin as one of our parameters as is the least "age-variable" protein, is clearly affected by nutrition, and is easy to obtain as it is included on most automated chemistry profiles.

Total lymphocyte count, the "poor man's measure of immunocompetence," is now widely accepted as a valid nutritional assessment tool. The direct relationship between TLC and nutritional intake has been documented.

Hemoglobin is affected, of course, by many factors, not just nutrition. However, we chose to include it as one of our survey parameters because it is easy to obtain, often recorded incidentally regardless of whether one is investigating the patients's nutrition, and can serve as a "red flag" of potential malnutrition in the absence of other recorded parameters.

The most valid anthropomorphic measurement of nutritional status seems to be weight loss over time. Many other measurements have been suggested, including triceps skin fold and midarm muscle circumference, but the validity of these values in the elderly has not been established. In fact, extensive tables of anthropomorphic measurements purported to be new norms for the elderly have been constructed from the National Health and Nutrition Examination Survey (NHANES) data, but this survey did not include any patients over 74 years old. We initially planned to use as our final parameter, weight loss in the 6 months preceding nursing home admission. However, lack of documentation of this information made it impossible for us to use this parameter, and we were obliged in part I of the study, tolook for documentation of weight only.

The theoretical problems encountered in the use of any one or any combination of these nutritional assessment parameters have recently been well reviewed and further discussion is beyond the scope of this paper. In summary, we feel that for practical use, in the designing of forms that will actually be used by nursing homes, the most valid approach to screening for malnutrition in residents is to check serum albumin, total lymphocyte count, hemoglobin, and weight and height.

Given the clear-cut increase in morbidity and mortality in any malnourished population, and the reversibility of a significant number of cases of malnutrition, we feel a strong call for improving the nutritional evaluation of patients upon admission to nursing homes is in order. The cost of such evaluation is minimal.

Having determined that in general, documentation of malnutrition and systematic evaluation for it is poor to nonexistent, we followed up our initial study with an in-depth study of the status of 50 patients at one of the previously studied facilities. Table 2 & 3 illustrate the assessment instrument, a scoring system based on publications of Seltzer, et. al. in 1979, which allows an estimation of degree of nutritional depletion based upon actual values of pertinent labs and weights.

We found a 72% incidence of some degree of malnutrition. Twenty percent of residents fulfilled the criteria for severe nutritional depletion.

The findings of this part of the study underscore the gravity of the problem of malnutrition in the chronic care setting. While similar studies have not documented equivalent rates of malnutrition it is important to remember that the protocols used to determine malnutrition differ from study to study and therefore data are not generalizable. Only by standardization of a nutritional assessment protocol can results be compared from facility to facility and a true picture of the problem of malnutrition in chronic care facilities be obtained.

This study also demonstrates the importance of using more than one parameter to evaluate nutritional status. Thirty-six percent (18 of 50) of the residents were found mildly depleted by virtue of an abnormality of one parameter only. Had there been less than three parameters, the nutritional depletion of many of these patients would not have been identified.

Early identification and prompt treatment of the malnourished nursing home resident should result in a higher quality of care and ultimately a substantial savings of nursing home dollars. A major recommendation is the development and implementation of a standardized nutritional risk protocol to effectively identify high risk patients in all nursing homes.

Suggested Reading:

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Seltzer M.H., et. al.: "Instant Nutritional Assessment." Journal of Parenteral and Enteral Nurtition (3):157-159, 1979.
Thompson, J.S., et. al.: "Nutrition and immune function in the geriatric population." Clinics in Geriatric Medicine 3: 309-317, 1987.
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Table 1. Frequency of Documentation of Nutritional Parameters

Number of Parameters Recorded	Number of Charts (%)
None	34 (14.6)
1	49 (21.1)
2	28 (12.1)
3	63 (27.2)
4	58 (25)

Table II: Nutritional assessment.

Nutritional-risk parameters	Adequate *0 point*	Mildly depleted *1 point*	Moderately depleted *2 points*	Severely depleted *3 points*
Serum Albumin (g/dcl)	>3.5	3.4-3.0	2.9-2.1	<2.1
Total peripheral lymphocyte count (mm^3)	>1500	1499-1200	1199-800	<800
Body weight status (*Table III*)	No weight loss	Mild weight loss	Moderate weight loss	Severe weight loss
Overall nutritional risk status based on three above parameters	Adequate total points—0	Mildly depleted total points—1	Moderately depleted total points—2	Severely depleted total points—3

Table III: Weight loss.[15*]

Time	Mild weight loss *1 point*	Moderate weight loss *2 points*	Severe weight loss *3 points*
1 week	<1%	1%-2%	>2%
1 month	<5%	5%	>5%
3 months	<7.5%	7.5%	>7.5%
6 months	<10%	10%	>10%

* % Weight loss = $\frac{\text{Usual weight} - \text{Current weight}}{\text{Usual weight}} \times 100$

CHARACTERIZATION OF ANOREXIA IN NURSING HOME PATIENTS

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Health care professionals working with elderly in both community and nursing home settings frequently encounter patients who have lost interest in food and are not able to ingest adequate calories and protein to maintain health. Often there is no obvious physical or social reason for this apparent diminuation of a drive which is basic to life. A loss of appetite is termed anorexia. Anorexia nervosa is a well characterized cluster of symptoms which occurs mainly in adolescent females. The phenomenon has been less well recognized or characterized in older adults (1). The term geriatric anorexia (or sometimes age associated anorexia) has been suggested for this condition in older adults in order to differentiate it from anorexia nervosa. Geriatric anorexia differs from anorexia nervosa in several ways: (1) patients are not obsessed with body image, (2) the loss of appetite is one of the first symptoms, rather than a later development, and (3) the condition occurs equally in men and women (1). Information on the prevalence of geriatric anorexia and its sequelae, poor weight status, is sparse (2); speculation as to causes include depression, poly-pharmacy (3), and suppression of appetite control mechanisms (4, 5). Anorexia and poor weight status puts a patient at high risk for malnutrition (6). This study was undertaken to determine the extent of unexplained anorexia and poor weight status in nursing home patients and to describe some factors associated with these conditions.

Methodology Approximately 30 medical charts, selected randomly in each of six Intermediate Care Facilities, were reviewed to determine numbers of patients noted to have anorexia or poor weight status. Anorexia was defined as chart notation of either poor appetite status on admission or poor appetite for two or more weeks. Poor weight status was defined as involuntary loss of more then 10% of body weight within 6 months, or less than 80% of Ideal Body Weight (1). Additional data were collected on length of stay, age, gender, conditions/medications liable to cause anorexia, nutritional interventions and outcomes. Data were also collected on when the problem developed and type of problem. Only data available through chart review were collected. In four homes (B,D,E,F) current patient charts were reviewed; in two (A,C) charts were retrospectively reviewed for patients exiting the home during 1987. Reviews were completed on 164 charts. Patients with cancer or other diseases known to cause cachexia were excluded.

Findings Of the 164 patient charts reviewed 96, or 59% were classified as having a problem. Table 1 shows the type of home, and the number and percent of patients identified as problematic. The percent ranged from 43% to 83%.

Table 1. Type of nursing home, number of charts reviewed and number and percent of patients with appetite/weight problems.

NURSING HOME	TYPE	NO. CHARTS REVIEWED	NO. PROBLEM PATIENTS	PERCENT
A*	philanthropic	27	18	67%
B	private, for profit	29	15	52%
C*	private, for profit	26	15	58%
D	public, non-profit	29	24	83%
E	philanthropic	30	14	47%
F	private, for profit	23	10	43%
	TOTALS	164	96	59%

*Retrospective Review

Table 2 shows lengths of stay and ages of patients reviewed in each home. Nursing Home (NH) A had considerably shorter lengths of stay and Nursing Home F considerably longer than the other homes. Nursing Homes C, B, D, and F are free standing, whereas A and E are within multi-level residential facilities for elderly. The mean age was lower in NH D, which is the County Home.

Table 2. Length of stay and age of patients reviewed.

	HOME	LOS(mos.) X ± (s.d.)	AGE(yrs.) X ± (s.d.)
Current:	B	25.6 (14.5)	86.3 (7.9)
	D	26.0 (24.3)	77.6 (11.4)
	E	18.8 (19.9)	81.9 (13.2)
	F	51.9 (59.5)	85.3 (9.2)
Retrospective:	A	8.0 (10.5)	83.9 (6.9)
	B	19.9 (15.9)	85.6 (7.0)

Table 3 shows the categorization of patients by gender, and by time of occurrence of the problem. Occurrence of the problem was noted as prior to admission (PTA), within 1 month of admission, or after 1 month post-admission. The data are displayed by nursing home rather than aggregated so that the consistency of patterns by gender and time of occurrence are clear. For males the rates ranged from 40% in Homes C and F to 86% in Home D. For females the rates ranged from 42% in Home E to 82% in Home D. Rates for males and females tended to be similar in any one home. Totals for currently reviewed homes for males were 56% and for females 55%; in the restrospectively reviewed homes male rate was 56% and female rate 68%. Overall, males males exhibited a problem rate of 60% and females 59%. Most patients exhibited the problem on

admission; this pattern was the same for males and females, and for current and retrospective reviews.

Table 3. Categorization by gender and time of occurrence of the problem.

	MALES					FEMALES				
HOME	RATIO*	%	PTA	<1 MO	>1 MO	RATIO*	%	PTA	<1 MO	>1 MO
B	3/6	50%	1	1	0	12/23	52%	10	0	2
D	6/7	86%	5	0	1	18/22	82%	10	2	6
E	4/6	67%	4	0	0	10/24	42%	7	1	2
F	2/5	40%	2	0	0	8/18	44%	5	0	3
A	5/6	83%	5	0	0	13/21	62%	10	2	1
C	4/10	40%	2	1	1	11/16	69%	4	3	4
Total	24/40	60%				75/128	59%			

* RATIO= # with problem/# charts reviewed

Table 4 shows summary data for types of problems exhibited by patients. In currently reviewed charts 42/63 or 67% of patients exhibited both appetite loss and poor weight status; In retrospectively reviewed charts 26/33 or 79% exhibited both. About 10-20% of charts noted appetite only problems, which may reflect the subjective nature of this type of observation, rather that a true problem. Other possible interpretations include possible failure to monitor/chart patient weight. The 10-20% of patients exhibiting weight status problem only may be interpreted as examples of increased metabolic requirements resulting from infection, restlessness, wandering, or tremors. Strategies for dealing with these types of problems might be quite different than intervention for anorexia.

Table 4. Classification of patient problems by current vs. restropectively reviewed charts.

	NO.WITH PROBLEM	APPETITE + WEIGHT	APPETITE ONLY	WEIGHT STATUS ONLY
Current:	63	42 (67%)	11	10
Retrospec:	33	26 (79%)	2	5

Since major disease states known to be associated with loss of appetite and wasting were excluded, association of anorexia and weight loss with specific diagnoses was not attempted. Rather, an attempt was made to note conditions or symptoms, and associated drug use that might impact on appetite/weight status. When rank ordered, patients exhibiting confusion, charted as Organic Brain Syndrome (OBS), Alzheimers, or Dementia accounted for

42/96 or 44% of the problematic group. The next largest group was that of osteoporotic/arthritic patients, and accounted for only 7/96 or 8% of the problem group. No other clear pattern seemed to emerge. Other than the drugs associated with confusion and dementia, namely major tranquilizers, no clear association between drug use and appetite/weight status was detected.

Reviewers noted if problem patients were monitored, if intervention was attempted, and if the problem was resolved. Most common interventions included liquid supplements, altered portion sizes, altered textures, and increased snacks. Monitoring was done on 85/96 or 89%, intervention was attempted in 71/96 or 74/% and resolution was achieved in only 16/96 or 17% of cases.

Conclusions Geriatric anorexia and its subsequent poor weight status is a prevalent and serious problem in nursing home patients. Onset in most cases occurs prior to admission so that health care workers in community based long term care need also to appreciate the prevalence of this poorly understood phenomenon. It is unclear why resolution rates are so low. Further study is needed to determine if anorexia is truly an unavoidable condition, to determine if professional or facility response is inadequate, or if there are physiological aberrations involved which we must understand better in order to correct.

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ACCIDENTS, THE ELDERLY AND "THE GOLDEN YEARS"

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In 1970 world-renowned author, Georges Simenon wrote: "In 1960, 1961 and 1962, for personal reasons, or for reasons I don't know myself, I began feeling old, and I began keeping notebooks. I was nearing the age of sixty. Soon I shall be sixty-seven and I have not felt old for a long time." (Georges Simenon, When I Was Old, Harcourt, Brace and Javanovich, 1970, 1).

This study was undertaken jointly by the Macon-Bibb County (Ga.) Health Department and Georgia Southern College. Its purpose was to determine the accident rate among the elderly residents of five self-care, high-rise apartment complexes located in Macon. It was also concerned with the identification of the causes of accidents, and the effect of accident prevention programs.

Research Design

A questionnaire collected information on accidents suffered by the respondents in the preceding three years, together with demographic data and information on the respondents' life styles. Based on a previous study (1983), one problem the research design sought to address was getting persons not experiencing accidents to complete the questionnaire. A field interviewer worked with the building managers to obtain maximum response, and assisted persons who had difficulty filling out the questionnaire, which was printed in large, easy-to-read type. A total of 453 usable replies were received, a response rate of 53 percent, with returns by facility ranging from 40-63 percent.

Findings: Frequency Distributions

Of the 453 respondents, 91 or 20 percent reported an accident in the two years preceding the study. Seventeen (or 4 percent of the overall group) reported a second accident within the same time period. Only one person reported a third accident. Falls constituted 74% of the reported accidents, distributed as follows:

Type of Accident	Number	Percent
Inside fall	39	43
Outside fall	16	18
Non-specified fall	11	12
Auto accident	17	19
Passed out	3	3
Unusual ("Freak") accident	2	2
Choked on food	1	1
Other accidents	2	2
TOTAL	91	100

Residents were asked to specify the date their accident(s) occurred. For the 75 persons able to do so, the three heaviest months were May (11), June (10) and January (9). The most accidents occurred in the second quarter (27), the least in the third quarter (12). Fifty nine percent of the accident victims consulted a physician, 26 percent required hospitalization. Forty four percent of those suffering accidents reported changes in their life style as a consequence. Nearly half those indicated they were taking greater care to avoid accidents.

Findings: Statistical Analysis

Crosstabulation separately considered those who reported accidents, and those who did not. Findings supported by statistical analysis of differences in group means used the .01 significance level unless otherwise indicated.

The following were not significantly associated with the accident rate: sex, frequency and type of exercise, whether relatives lived in the area, frequency of relatives' visits, participation in accident prevention and safety programs, health concerns and visits to the health department.

Even though no general conclusion emerged from analysis of statistical association, crosstabulation by age provided the study's most significant findings.

	Accidents - Yes		Accidents - No	
Age Grouping	Number	%	Number	%
20-29	1	9	10	91
30-39	1	12	7	88
40-49	1	8	11	92
50-59	4	21	15	79
60-64	7	30	16	70
65-69	8	12	56	88
70-74	9	14	55	86
75-79	16	19	68	81
80 and Over	41	25	122	75
TOTAL	88	19	360	81

What stands out is the sharp and statistically significant drop in the accident rate for those in the 65-69 and 70-74 age groups compared to those in the age groups immediately preceding and following. Given their decreased ability to avoid accidents, why did the accident rate decline? A major objective of the research was to apply a wide range of statistical techniques in seeking an answer to this question.

Examination of the correlation matrix revealed extensive intercorrelations among the the 21 variables around which the study was organized. Factor analysis was used to analyze the underlying structure of the data set, and five factors produced Eigenvalues >1:

Factor 1 = Miles driven and number of trips taken (1.903)
Factor 2 = Activity level, health worries, exercise frequency (1.478)
Factor 3 = Relatives in area, frequency of their visits (1.296)
Factor 4 = Age and kind of exercise (1.147)
Factor 5 = Complex in which lived and accidents (1.070).

The first four factors are logically predictable interrelationships among the life-style variables. Factor 5 involves accidents and warrants additional analysis. T-test analysis confirmed statistically significant differences in the accident rates among the five complexes, ranging from 10% to 28%. However, there was no statistically significant relationship between the percentage distribution of people 65-74 years old and the accident rates in the various complexes. Based on interviews with the managers and physical site evaluation, no explanation emerged for the difference in accident rates by complex.

Target Group Analysis

Given its lower accident rate, the 65-74 year-old group was chosen for further analysis. The program DISCRIMINANT did no better than chance classifying respondents into the two age groups, 65-74, and all others. On the basis of T-TEST analysis of differences in group means, there were three statistically significant findings. The 65-74 group was more likely to own an automobile ($p=.01$), drove more miles per year ($p=.01$), and classified themselves as being more active ($p=.05$). Also, one after-the-fact, rather than potential causal relationship was uncovered. Accident victims were more concerned about falling and being careful than were non-victims. Also of interest were expected relationships which were not significant. For example, length of time in residence, and exposure to accident prevention, safety and health programs were not related to the accident rate.

Implications of the Study

The findings of the study are inconsistent with prior research on the aging process. From age-60 on there is ample evidence documenting a steady decline in measures of physical and mental activity. After age-80, the rate of decline increases sharply. Cross-sectional and longitudinal data for which this holds true include measures of perceptual skills, athletic ability, crystallized and fluid intelligence, auditory reaction times, visual symbol recognition and interpretation, writing speed, and cognitive flexibility. There is a similar trend in accidental death and accident rates reported by the National Safety Council. This is consistent with the portrayal of the elderly in the literature as being less able to avoid accidents due to impaired perceptual abilities, reaction-times, and organized movements compared to younger persons. On the above basis, compared to the two age groups immediately preceding, those in the sample 65-74 should be more accident prone. Instead, the accident rate drops, despite increased exposure due to a higher level of auto and other travel, and a higher self-reported activity level. Overall, the results tend to support the activity vs. the disengagement view of the aging process.

Disengagement theory suggests that persons fare better in old age if they accept the inevitability of reduction in social and personal interactions. Activity theory, on the other hand, suggests that maintenance of a high activity level and personal interaction is important to most individuals as a basis for attaining and maintaining satisfaction, self-esteem and good health. Presumably the latter also includes freedom from accidents. If so, then the results of this study tend to support the activity hypothesis. However, conclusive proof cannot be offered as long as it is not clear whether higher levels of activity lowered the accident rate, or whether persons who avoided accidents were capable of maintaining higher activity levels as a consequence. On the basis of statistical association, and without further supporting information, one cannot fix the direction of the causal arrow with any degree of certainty. This clearly provides a direction for future study.

In conclusion, the study suggests that the elderly can no longer be studied as a target population: persons 65 and over. Instead, segmentation, minimally by age, and also on other bases, is clearly indicated. The 65-74 time window with its lower accident rate is consistent with the "Golden Years" theory of aging. This suggests that, after a period of initial adjustment and adaptation, persons learn to adapt to the aging process. In this regard, a lessened susceptibility to accidents is assumed as consistent with increased quality of life overall. This suggests that if other measures of the overall quality of life were to be obtained, the significance of the 65-74 age window could similarly be validated.

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II.

RESEARCH STUDIES IN AGING: PART 2

Objectives:

Upon completion of this presentation participants should be able to:

1. List reasons that research studies are needed to examine the effectiveness of nursing interventions in diminishing stress levels of older family caregivers as related to the functional status of the elder recipients.

2. Identify the components of an instrument to measure serenity among the elderly.

3. Examine study results that may have direct implications on the leadership styles employed by researchers who work with the elderly.

4. Based on the three reasons that decreased social integration results from institutionalization, propose interventions that might be developed.

Authors:	Topic:
Elizabeth Murrow Bains, RN, Ph.D. Clemson University	Older Adults as Caregivers and Care Recipient
*Kay T. Roberts, Ed.D., RN, C Linda Fitzgerald, MSN, RN University of Louisville	Development of an Instrument to Measure Serenity
*Mary Ann Adams, Ph.D. Cecilia Rojas-Camero, BS, MS, RN, C University of Southern Mississippi	Effectiveness of Leadership Style in a Small Group, Sex Education Workshop for the Elderly
Sharon Eylar Anderson, Ph.D., RN University of North Carolina at Greensboro	An Ethnographic Study of the Effects of Institutionalization on Social Integration in a Life Care Community

*Denotes Presenter

Title: Older Adults as Caregivers and Care Recipients
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Introduction: Caregiving is usually conceptualized as being provided by professionals in institutions however, the majority of health care is given by family members in the home. In fact, approximately 80% of the care needed is provided by a family member or friend (Chappell, Strain, & Blandford, 1986). Not only do family members provide the majority of health care, but also older adults give more than half the care needed by other older adults (Bennett, 1983).

Despite the fact that older adults provide most of the care for other older adults, only about 4% of the $120 million that is spent on health care in the United States for elders, is for home health care services (AARP, 1988). Of the remaining amount approximately 44% goes to hospitals and 21% each is given to physicians and nursing homes. In addition, older adults experience more chronic than acute conditions. According to the AARP (1988) most older persons have one chronic illness and many have multiple conditions.

Purposes: A purpose of this study was to measure the level of stress experienced by older family caregivers and to measure functional status of the care recipient who was being cared for in the home by caregivers who also served as subjects in the study. Another purpose was to determine the outcomes of selected nursing interventions provided by professional nurse researchers in the subjects' homes.

Conceptual Framework: The theoretical framework for this study was based on several approaches including: Strauss's et al (1984) conceptualization of the impact of chronic illness on the person afflicted and on the family involved, Hymovich's (1987) model based on the developmental tasks of the individual with a chronic illness and its impact on the family providing the care, in which nursing interventions are based on assessed needs, and Carnevali, Mitchel, Woods & Tanner's (1984) perspective for viewing the interrelationship between nursing care, functional health status and the activities of daily living. According to Carnevali et al., nursing is concerned with the significance or meaning of these activities both to the individual afflicted and to the family.

Methods: The design for this study was a quasi experimental pretest-posttest design. The subjects for this research were recruited from the community, public healh departments and from a Nursing Center located in a College of Nursing. All of the subjects lived in a semi-rural southern state. Subjects were assigned to either the treatment or

control group based on their availability and willingness to participate in the study. The first ten subjects were assigned to the pilot group and the next 30 caregiver/care recipient dyads were placed in the treatment group. The final twenty-eight caregiver/care recipient dyads that were recruited were placed in the control group. All subjects in both groups were 65 years of age and over and had received the majority of needed care from the primary caregiver for at least one month previous to being admitted to the study.

Subjects in the treatment group received nursing interventions in their homes from the nurse researchers based on assessed needs and included the following services: personal hygiene assistance, educational sessions and referral. Subjects in the control group received the same amount of care that they would have if they were not in the study, however, referrals and other necessary care was given if needed. The subjects in the control group also received two home health visits from the nurse researchers for purposes of data collection. There were no significant differences between the two groups on any demographic or perceived health status information.

Instruments: Two instruments were used: (a) the Caregiver Stress and Coping Instrument (CSCI) and (b) the Pfeiffer, (1982) Functional Assessment Inventory (FAI). The CSCI is designed to measure family caregiver stress and coping. It is a modification of Hymovich's (1983) "Chronicity Impact and Coping Instrument: Parent Questionnaire." Most of the original items were retained, however items specific to the developmental level of children were substituted with items related to the adult developmental level. A stress score is obtained from the help needed and concern sections and ranges from 31-77 with a higher score indicating greater stress. The mean post test score for this sample was 42, suggesting that stress was present in the caregiving role but not excessive. The content validity of the CSCI was established through content experts: Older adults and professionals. For this research, pretest scores were significant preditors of posttest scores ($t=10.17$, $df=64$, $p<.05$) indicating that the modified instrument is reliable.

The FAI provides a measure of the functional status of older adults in a variety of settings and examines functioning in five areas: social, economic, mental, physical and activities of daily living. The score can range from 1 to 5 in each area with a cummulative score between 5 and 30, with 30 representing the least desirable score, suggesting serious impairment and few, if any resources. The mean posttest FAI score for this sample was 18. This score suggests that for this sample of older persons some were severely impaired. According to Cairl, Pfeiffer, Keller, Burke and Samis (1983) the reliability and validity of the FAI are satisfactory but additional testing is needed in future studies. For this

research, pretest FAI scores were significant preditors of posttest scores (t=17.40, df=64, p<.05) indicating that the instrument is reliable.

Findings: Results related to the hypothesis, stress scores will be lower in caregiving subjects who received nursing interventions than those who did not, are presented in Table I.

Table I
t Test for Change in
Pre-test to Post-test Stress Scores

Variable	M	SD	t*
Control (N=28 dyads)	1.14	4.28	1.36
Treatment (N=30 dyads)	-0.7	5.83	

*p.<.05

The results indicate that there was not a significant change in the level of caregiver stress from pretest to posttest due to the treatment factor (t=1.36, df=57). Evidently, for this sample of older adult caregivers the presence or absence of nursing interventions did not significantly alter stress scores in older family caregivers. Some possible reasons for this might be the time and duration of the interventions and the deterioration of the health status of the caregiver.

Results related to the second hypothesis, functional status will be better in care recipients who were in the treatment group than those in the control group, are presented in Table II.

Table II
t Test for Change in
Pre-test to Post-Test Scores

Variable	M	SD	t*
Control N=28 dyads	0.42	1.79	.78
Treatment N+30 dyads	0.06	1.76	

*p<.05

There was not a significant difference in the pretest to posttest change scores on the FAI for this sample of care recipients who were in the treatment group (t=.78, df=57) indicating that receiving nursing interventions did not improve the care recipients functional status.

However, the results indicated a significant Pearson Product-Moment Correlation Coefficient (r=0.45, p<.05)

between caregiver stress scores and functional status scores. This finding suggests that for this sample, caregiver stress is associated with the degree of impairment in the care recipient.

The findings indicate that fatigue, isolation, and financial problems are major concerns for caregivers. The majority of the caregivers, 66% rated their health as good or poor and 78% indicated that they were satisfied with the caregiving role. Both the control and treatment groups indicated that prayer was frequently utilized as a method of coping with the problems in family caregiving. Other methods included: seeking assistance, ignoring the problem, crying, and taking drugs.

Care recipients obtained better scores in social and economic areas on the FAI than in activities of daily living indicating serious impairment in performing personal care tasks. Mental and physical health in the care recipient was also seriously impaired in this sample of caregivers.

The results of this study confirm the theoretical underpinnings of the research, that family caregiver stress is related to the functional status of the care recipient. It is necessary that church and community groups be mobilized to assist family caregivers and relieve their stress and isolation. Additional research is needed to determine the efficiency of service programs designed to assist caregivers and to examine the quality of home health care. Legislation is needed to assist family caregivers to cope with increased health care costs and the responsibility for caring for persons in the home.

References available upon request.

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Development of an Instrument to Measure Serenity

Serenity is a concept that has been pursued by persons from all walks of life. Defined as peace amid the storm, serenity holds promise for an improvement in the quality of one's ife. The idea that one can experience inner peace despite external events is a welcome perspective to persons who are caught in painful and seemingly irresolvable problem situations. Elderly clients comprise one group who frequently find themselves in this dilemma. Thus, serenity has implications as a practice concept. However, despite popular use of the word, meaning intended by authors is often vague and implicit. To fully examine how serenity can be applied to care of the elderly client, meaning must be clarified and communicated to professionals. Further, in order to evaluate interventions designed to facilitate the achievement of serenity, there is a need to develop a way to measure the existence of serenity. The purpose of this presentation is to communicate results of an analysis of serenity and the development of an instrument to measure serenity.

A concept analysis of serenity was completed as a first step toward measurement of the concept. The process of analysis was that recommended by Walker & Avant (1983). First, one identifies all uses of the concept that can be discovered. From this information defining attributes, antecedents, consequences, and empirical referents are determined. Model and contrasting cases of the concept are developed. Although accomplished, these steps will not be reported here due to lack of space. Five experts on serenity were enlisted to assist with the process.

The analysis focused upon serenity as a human experience that involves mood, feeling, thought, state of being, and level of consciousness. Serenity was first used to describe a positive mood state in 1599 (Oxford English Dictionary, 1961). It was described in thesarauses as a calmness of mind, evenness of temper, coolness, composure, tranquility, repose, and a state of being unruffled and unperturbed (Crabb, 1945; Funk & Wagnall, 1947; Laird, 1948). According to Oates (1979), Leibman (1946), and Reed (1987), serenity is related to peace of mind. Serenity

is, however, used to refer to something more than peace of mind. Pfau (1988) defined serenity as peace that passes all understanding. Bodley (1955) and Marshall (1978) referred to serenity as an inner peace. Gerber (1986) defined this inner peace as unrelated to external events. Serenity is used as a spiritual concept. Spirituality in this study is meant to encompass values, meaning, and purpose relationships and a turning inward to human traits of honesty, love, and spirit. It may or may not refer to religion (Dossey, Keegan, Guzzeta, & Kolkmeier, 1988).

Defining attributes are those characteristics which occur over and over again in instances of the concept. Critical attributes are those defining characteristics that must be present for the concept to exist. Ten critical attributes were identified: (1) the ability to detach from desires and/or emotions and feelings; (2) the ability to be in touch with an inner haven of peace and security; (3) a sense of connectedness with the universe; (4) a trust in the wisdom of the universe; (5) the habit of actively pursuing all reasonable avenues for solving problems; (6) an ability to accept situations which cannot be changed; (7) a way to give unconditionally of one's self; (8) forgiveness of self and others; (9) the ability to let go of the past and the future and to live in the present; (10) a sense of perspective as to the importance of one's self and life events.

Antecedents are those events which must occur prior to the occurrence of the concept. Prior to the experience of serenity, one must be able to conceptualize, have an awakening to the existence of serenity, have a desire for the state of serenity, and have a way to learn how to be serene. Consequences are those events or incidents which occur as a result of the occurrence of the concept. Henry (1986) suggested a decrease in secretion of stress hormones with the experience of serenity. McKenna (1977) reported the presence of alpha brain waves when one experiences serenity. Jackson (1977) stated that serene people are calm and confident, but never pushy, and that they exude an inner peace that makes others stand in awe of them. Gerber (1986) described the consequences of serenity as self-possession in difficult and trying times, acceptance of one's self as a worthy individual, a healthy mastery of one's emotions, improved interpersonal relationship, an increase in zest for living, and the ability to accept with equanimity whatever trails or tribulations are sent one's way. An increase in compassion seems to emanate from the feeling of connectedness.

Empirical referents are classes of actual phenomena which by their existence or presence demonstrate the occurrence of the concept itself. Self-report is one referent. There was no instrument available to measure serenity. This study represents

an attempt to develop an instrument and thus clarify this domain.

The critical attributes served as a basis for development of the instrument. Multiple questions were written for each of the attributes and circulated by mail to the experts who were asked to rate each question for its effectiveness in measuring the corresponding attribute. A rating scale from 1 to 3 was used with 1 representing that the question would yield maximum amount of information about the attribute and 3 yielding minimal information. Questions which received a "1" from at least three of the experts were retained for use in the instrument. A total of 61 statements were selected for use in the Serenity questionnaire. Participants were asked to rate the frequency with which they had the experiences described by the statement. An example statement is, "I am aware of the inner peace." A scale of 1 to 5 was used with 1 representing "never" and 5 "always," with no word descriptors for positions 2, 3, and 4. Item 62 asked participants to self-rate their level of serenity. Questions 63-75 were demographic items. The instrument was administered to 60 oriented, elderly volunteers who resided at a non-profit independent and semi-independent living apartment complex. Results from this group are not available on this date. However, the consulting statistician administered the first 62 items of the instrument to 44 university education students enrolled in a graduate class on measurement of personality to serve as a teaching strategy to clarify course concepts and to obtain information useful to the researchers. Data were analyzed using SPSSX Release 3.1. A Cronbach alpha of .9397 was obtained for the instrument. Alpha scores for individual attributes, in rank order, were Inner Haven = .8961; Trust = .8111; Living in the Present = .7947; Connectedness = .7808; Problem Solving = .7519; Detachment = .6474; Giving of One's Self = .6321; Perspective = .6401; Acceptance = .5825; and Forgiveness = .3251. Preliminary results indicated that the instrument was measuring a discrete construct with a high degree of consistency, i.e., reliability. The concept analysis with consensual validation by the experts of both attributes and test items is one measure of construct validity. However, more extensive testing of the instrument is needed to establish reliability and validity of the instrument.

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EFFECTIVENESS OF LEADERSHIP STYLE IN A SMALL GROUP SEX EDUCATION WORKSHOP FOR THE ELDERLY

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Sexual behavior of older people in western societies traditionally has been repressed, criticized, ridiculed, and condemned. Human sexuality in old age most often has been determined by stereotypes, misconceptions, fantasies, and a lack of knowledge (Newman & Nichols, 1960). The individual aspects of elderly sexuality, including interpersonal relationships and sexual expressions, have been marked by the questionable assertion that as individuals grow older, they become asexual (White, 1982). While our culture has emphasized sex education for adolescents, sex education and information for the elderly has been minimal (White & Cantania, 1982). Research on effective sex education models to use with the elderly population has been virtually non-existent. Literature on sexuality in later life has been minimal. Love and Sex After Sixty by Robert Butler and Myrna Lewis (1976) is one of the few monographs to address later life sexuality. Recently, in response to this gap in the literature, the University of Iowa Gerontology Project has published a much needed updated book on Sexual Health in the Later Years (Waltz & Blum, 1986). However, the issue of how to disseminate this information to the elderly population in manner which they can accept is still unresolved.

According to White and Catania (1982), older people are beginning to challenge society's tendency to measure sexuality solely through sexual performance and are expressing their desire for more information regarding sexual health. Sexual health, according to Waltz and Blum (1986), refers to "sexuality as an attitude of mind as well as a bodily function; a comfortable accommodation with one's sexuality in later years of life is an important part of general physical and mental health." Sex education for the elderly in the form of small group education/intervention sessions appears to be an appropriate vehicle for increasing sexual health. Burnside (1976), a pioneer in the fight for the rights and needs of older citizens, has delegated the responsibility of sex education for the elderly to the nurse, primarily because this health professional is specifically educated in the provision of care to the older adult.

The present study assessed the small group sex education/intervention approach using White's Aging Sexual Knowledge and Attitudes Scale (1982) as a pre-and posttest. Past studies have revealed that even if the elderly person does not participate in sexual behaviors, he/she will become more tolerant of such behaviors after similar workshops (White & Cantania, 1982). The current research examines change in sexual attitudes and sexual knowledge of the well elderly regardless of their actual level of sexual behavior.

Subjects were recruited from a senior services center facility located in a southern city. It is a program designed to meet the needs of the well elderly who desire daily supervision and care. Participants must be 60 years of age, ambulatory, continent of bowels and bladder, and able to follow simple instructions. The entire population of participants consists of 49 retired individuals. Seventy percent are black and 30 percent are white. The average annual income of the participants is $4800. The participants were recruited voluntarily after an oral presentation of the purpose of the study. The research project was approved by a university human subjects committee, and a consent form was signed by each participant.

Fifteen participants took the pretest. Twelve participants attended the small group workshop sessions, two of whom had not taken the pretest. In all, ten subjects took the pretest, participated in the workshop, and took the posttest. Nine of the subjects were Protestants, and one was Catholic. Nine of the subjects' spouses were deceased. These nine subjects lived alone. The remaining subject was married and lived with her spouse who did not participate in the study. There were seven females and three males. Eight had four to six years of elementary education, two had high school diplomas, and one subject had completed two years at a junior college. All the participants received Social Security checks as means of economic support.

The Aging Sexual Knowledge and Attitudes Scale (ASKAS) developed by White (1982) was administered individually to subjects before and after the workshop sessions. Individual interview was selected to eliminate problems related to reading and comprehension ability. The subjects then participated in two, hour-and-a-half sessions on sexuality in later life. The pretest was given a day prior to the workshop sessions. The posttest was administered the week following the sessions. The instrument was administered by sex-matched interviewers. The ASKAS (White, 1982) consists of 61 items related to knowledge and attitudes toward sexuality in the elderly person. The instrument may be administered individually or in groups via personal interview or by pencil-paper format and is recorded on a seven-point Likert scale as to degree of agreement=1 or disagreement=7.

The small group workshop sessions were conducted by two graduate students, one male and one female. Presentations were followed by small group discussion/intervention sessions. Materials presented included the following: Session I: a lecture, a discussion on myths and
stereotypes about sexuality and aging, sexual attitudes and expressions in later life, a filmstrip with audiotape entitled "Sexuality in Aging", and a small group discussion;
Session II: a lecture, discussion on physiological and physical aspects of sexuality and aging, transparencies of sexual characteristics of male and female, and a small group discussion. Lecture sessions included materials on the normative changes in

regard to sex and aging, the benefits of sex in old age, the social hindrances to sexual expression and intimacy, the problem of impotence and its treatment, and other physiological, psychological, and sociological factors relevant to sex and aging.

A correlated, or dependent, t test was used to analyze the differences between the pretest and posttest mean scores on the ASKAS. No difference was revealed at the .05 level of significance.

The lack of a significant change in sexual attitudes and knowledge of the group could have been influenced by the fact that all ten subjects considered themselves to be very religious persons. Even though they voluntarily participated in the testing and in the workshop, some degree of resistance was noted especially when answering some of the questions they considered moral issues such as "Sexual relations outside the context of marriage are always wrong" to which all the participants answered "agree." The majority of the subjects considered the topic of sexuality taboo and were not interested in modifying their views concerning sexuality. To the question "I would like to know more about the changes in sexual functioning in older years," eight of the ten participants answered "disagree." To the question "I feel I know all I need to know about sexuality in the aged," nine answered "agree."

The responses to attitudes about sex in nursing homes were unanimously negative in both pretest and posttest. Participants agreed with the notion that sex should not be permitted, much less encouraged and/or supported in nursing homes. According to Bandura's (1977) social learning theory, moral reasoning can be modified through exposure to certain divergent views; but in the case of performance preferences, modeled judgements might be learned but not expressed because they are socially or personally disfavored. In the small group setting, discussion did appear to be controlled partially through peer acceptance or rejection. The females would often ask the male members what they thought before responding to questions. When a group member did make a statement about an issue, the group would almost always unanimously support them. This would support Bandura's theory based on the fact that not only did they not express divergent views in the group, but neither did they express them on the personal follow-up test.

Another part of Bandura's (1977) social learning theory which also appeared to be supported in the study is the presumption that modeling of moral standards that are too discrepant with one's personal moral judgement cannot be assimilated due to cognitive dissonance. When sexual issues were presented which did not relate to sexual intercourse (i.e. the need for affection, the need to feel comfortable with your body image, etc.), the group was unable to separate these topics from the moral issue of "sex is wrong outside of marriage and we are not married." The group was unable to distinguish between sexuality and the sexual act. Therefore, if the sexual act is wrong, then learning about sexuality is wrong. In addition, for learning to occur, people must attend and remember what has been taught (Bandura, 1977). Short term memory

often is affected in aging individuals. This fact should be considered when a new topic is going to be introduced and when the learning experiences are expected to be recalled by the elderly.

Another important assumption of Bandura's social learning theory is that people cannot be influenced by modeling behaviors if they do not understand them. Detailed explanations of each one of the questions in the instrument were necessary before they were answered, and several synonyms and slang words were used before some of the vocabulary was understood by the majority of the subjects. Topics such as masturbation and secondary impotence were unknown to most of the participants; and even after the workshop when these issues were addressed, the responses remained unchanged, invalidating the hypothesis that attitudes can be changed with this type of small group sex education/intervention approach.

In relation to the administration of the ASKAS with elderly persons, most participants did not understand the use of the Likert scales rating. Therefore, no middle scores were recorded in the attitudes scales, only disagree=1 and agree=7. The vocabulary used in the ASKAS was not easily understood by the majority of the subjects. Future researchers who use this instrument should modify the descriptors for sexual behaviors into terminology adjusted to the educational level of the elderly person.

Lastly, the length of the ASKAS made use of individual interview as a testing procedure less than adequate. The physical capacity of sitting through the hour of questioning could have an effect on the subjects as was evidenced by the reluctance of the elderly to complete the sixty-one items.

The need for small group education/intervention workshops with the elderly concerning sexual issues is evidenced by the number of volunteers asking to be included in the group. However, for these workshops to be successful, new techniques should be considered. This study did yield valuable information for future gerontologists desiring to implement similar workshops. In order to communicate with the elderly concerning sexuality, the instructor must first emphasize that this is not a workshop on whether intercourse is right or wrong, but simply a group where one can discuss concerns and feelings about all of sexuality (which includes problems associated with being male and being female, the need for affection, the need to be hugged, etc.). To further abort the negative feelings about a workshop on sexuality, the nursing staff could ask a minister to be a co-facilitator of the group. There was a minister present in the workshops and the group appeared to be more comfortable communicating with him. The outcome of the workshop might also be more favorable if the groups were separated according to gender. In this setting some elders may feel freer to express issues which they feel might be misinterpreted by the opposite sex. In the sessions, the males appeared to be more comfortable communicating with the male leader, and the females appeared more comfortable communicating with the female leader.

The reader should be cautioned against generalization from this study to other elderly populations for the following reasons:

1. The topics covered in the workshop sessions and the vocabulary used by the counselors could have influenced the participants' receptivity to new ideas.
2. The personal style of the interviewers could have influenced the participants' response to the ASKAS in either a positive or negative direction.
3. The socioeconomic level and educational status of the participants could have influenced the response to the workshop.
4. The number of subjects was small.

It is recommended that future researchers conducting similar small group workshops include subjects from a variety of socioeconomic levels and educational backgrounds in order to increase the validity of the study. It is also recommended that the ASKAS be adjusted with vocabulary that will match that of the subjects to be tested. Small group education/intervention workshops which address the issues related to sexual health in the elderly pose a challenge for the gerontological nurse. These workshops are difficult to present as well as to measure the positive or negative outcomes. The field of gerontological nursing can not be passive concerning sexual healthiness of the elderly but must develop new and innovative methods of teaching and testing which can be positively received by the ever-increasing aging population.

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AN ETHNOGRAPHIC STUDY OF THE EFFECTS OF INSTITUTIONALIZATION ON SOCIAL INTEGRATION IN A LIFE CARE COMMUNITY

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The purpose of this research was to discover the impact of institutionalization as the result of physical illness on the social network of age peers residing in a life care retirement community. The research question addressed was: What happens to the social network of aged individuals who, due to physical illness, are required to move from independent life in the community to institutionalization within the same community?

The study site was a 17 year old, non-profit life care community (pseudonymed Golden Bells) located in a suburban region of a western state, 30 miles from a major metropolitan area. A main building housing activity centers, the community dining room, numerous apartments and the nursing facility, served as the hub for communal interaction. Residents living in adjacent patio homes or the high-rise apartment building walked up to 200 yards to the main facility. Admission to the community was contingent upon physician certification of the applicant's ability to live independently despite the presence of one or more chronic illnesses.

Golden Bells provided a number of options for those with health care needs. Homebound residents recuperating from acute or chronic illnesses were visited regularly by a nurse who administered prescribed medication on a daily basis. The latter service was also extended to those with cognitive deficits who could not reliably self-administer medication. Temporary admission to the community nursing home was offered to those requiring recuperative care following hospital discharge. Permanent admission to the nursing facility required apartment dwellers to surrender their domiciles for resale by the corporation.

The community consisted of 479 middle to upper-middle income individuals, age 65 or over; the majority were single or widowed women. Three hundred and eighty one persons resided in 321 apartments, while 98 were permanent nursing facility residents. The population included twelve married couples. Average resident age was approximately 78.

The study population was stratified by residence characertistics: fulltime apartment dwellers, apartment residents who had spent time recuperating in the nursing home on at least one occasion, and permanent nursing facility residents. Criteria for inclusion in the study included: 1) current or previous apartment residence for a minimum of one year (including nursing home residents) and, 2) the absence of mental impairment or disability.

Informants in each category were purposively selected on the

basis of study criteria and category representativeness for sex and marital status. The first sample category, fulltime apartment dwellers, consisted of eight informants; two men and six women, including a married couple, were interviewed. The mean age was 75.8 years. Among this category of informants, the average time spent residing in Golden Bells was 8.6 years with a range from 3 to 17 years.

The second category included nine apartment residents who had experienced at least one temporary admission to the community nursing home. Four men and five women, including a married couple, were interviwed. The average age was 80.5 years. Informants in this category lived an average of 8.3 years in the community; length of residence ranged from 1.5 to 17 years.

Eight individuals classified as permanent nursing home residents were included in the final category; all were widowed women. The mean informant age was 89.8 years with a range from 81 to 101.5 years. Informants spent an average of 8.75 years living independently in an apartment prior to relocation to the nursing facility; years of independent apartment living ranged from 3 to 13 years. Informants lived in the nursing home an average of 3.7 years with a range from 2.25 to 14 years.

Ethnographic data were collected using tape-recorded responses to open-ended and structured questions. Interviews averaged 2.5 hours in length. Data were transcribed, coded and collated using an ethnographic computer program.

In order to identify the components and interactive patterns of Golden Bells' social networks, informants were asked to describe community characteristics, social network formation, integrative activities, and the effects of illness on social integration. Emphasis was placed on the social consequences of institutionalization in the community nursing home.

A summary of informant responses revealed that the process of integration into the community usually began within the first few days of apartment residency. Newcomers were greeted by cohorts organized as a hospitality committee to welcome and orient new arrivals to community services and activities. This informal network activity was complemented by visits and information provided by the formal network of community employees.

Social integration occurred rapidly for newcomers who actively participated in community activities with cohorts sharing a common interest. New residents reluctant to engage in integrative activities due to a desire for isolation or because of limited social skills found that integration was a lengthy process.

There was a strong norm for active participation which

required, in most instances, that residents be physically capable of maintaining initially established patterns of social interaction. Able-bodied, socially active individuals, were fully integrated into the community and functioned as the ideal type against which others were evaluated and judged.

The event of illness, if temporary, was not viewed as a threat to integration. Continued residence in an apartment throughout an illness or temporary transfer to the nursing home did not jeopardize integration. Homebound individuals were supported by both formal and informal networks during recuperation. Since they could not participate fully in former social roles due to limited incapacitation, they were, for the period of their confinement, marginally integrated. Although unable to function normatively in active participatory roles, their status as homebound or temporarily institutionalized was not considered deviant.

The process of social dis-integration began when physical disability or illness required permanent admission to the community nursing home. Formal and informal networks acted jointly to disassociate dependent community residents from independent cohorts. Following a three month stay in the nursing facility, the resident, resident's family, and professional staff determined residency status. With a decision in favor of permanent confinement, residents were required to remove belongings from their apartments to facilitate resale.

Although the nursing facility was adjacent to the main dining room, the practice of sharing a common facility was terminated following complaints of apartment dwellers. One informant stated:

> They thought it was good for the (nursing home) people to be brought in by another relative or resident to eat in the main dining room. That had to stop. We saw too many either vomit at the table or pass out ...and that's not nice when you're in a dining room....so you shun that. Now there are people that come down (from apartments) to the dining room that are perfectly O.K. except for a wheel-chair...and that's nothing....or in double crutches...that doesn't mean a thing...but if they come from the (nursing home) into our dining room, that isn't right, so they have their own dining room now. It wasn't fair to the rest of us.
>
> (Female, resident 17 years)

Able-bodied apartment dwellers reported that they failed to visit friends in the community nursing home because: 1) entering the institution reminded them of their own potential, eventual fate, 2) the sensory impact of the institution and its residents were viewed as offensive, and 3) the lack of shared activities with dependent cohorts significantly reduced common interests.

According to able-bodied informants:

> I have a theory and I don't like it. I think they see themselves there. ...they visualize themselves there...I've even asked people to go and see someone... and I'm speaking of people that I consider very intelligent, and they say "Oh, I don't want to go see them...I don't want to go in (the nursing home)".
> (Female, resident 8 years)

> ....you can't do anything with them... I mean you can't go places with them...the friendship is still there, but of course it changes....Some people won't go into see them at all because they can't face reality...that that might happen to you sometime and you might be in that place. It's an effort to go down and they really don't have anything to talk about...because all they know is (nursing home) and it puts a strain on you.
> (Female, resident 11 years)

Findings indicated that physically disabled, mentally competent nursing home residents experienced a significant decline in social interaction with able-bodied community cohorts following permanent admission to the facility. The dis-integrative phenomena were identified by nursing home residents as the result of: 1) failure of friends and acquaintances to visit, and 2) declining physical health.

Nursing home informants identified reasons for limited visitation by apartment residents as dislike of the nursing home, having to traverse the distance to the facility, fear of interfering with institutional schedules, inability to tolerate the sensory impact of illness, apathy, and rejection by nursing home residents. Dependent residents stated:

> I wouldn't say there's very many (that visit.) ...these people come and go here...they die. I know a man that comes to visit these people..but I don't think there's more that four or six (apartment residents who visit.) Either they don't know them, or don't care, or not understand.
> (Female, resident 10 years)

> They won't come and visit as often because people don't like (the nursing home.) People don't want to come in (the nursing home.) They all dread having to come here...so they don't come to see you.
> (Female, resident 9 years)

> There's a hesitancy to come...this may be partly a personal matter...people don't like to see too much illness and suffering among their friends.
> (Female, resident 10 years)

> (Apartment friends) are getting too old and not able to get around...and I don't particularly want them.
>
> (Female, resident 9 years)

The dis-integrative process experienced by permanent nursing home residents was not experienced by apartment residents temporarily admitted to the institution during a recuperative period. Integration was maintained through visitation, occasional shared activities, and temporary assignment to the sick role.

> Some of them (apartment friends) came over. One of them used to come over and get me in the wheel chair and take me outside and we'd go out and set in the gazebo and places like that... maybe one or twice a week.
>
> (Female, resident 6 years)

> Nothing changes a great deal. I had the same people come to visit me in the (nursing home) that would visit me in the apartment. All my neighbors and friends...they could come in there and visit me and bring me things....and cheer me up.
>
> (Female, resident 9 years)

The dis-integrative social processes which accompanied permanent nursing home admission proved to be the antithesis of what institutionalized residents expected. One of the primary reasons cited for relocating to Golden Bells was the availability of age-peers for friendship and activities in later years and in the face of declining health and institutionalization. An apartment resident stated:

> One of the things that most of us living here think is so great about life care is we're all at the age where we're dreading the time when one or the other of us will have to go to a nursing home...and that nursing home will be clear across the city. And here it's not. It's just across the street and the person who goes to the (nursing home) still has the same family of friends that they had when they were living in the apartment. That's what's so great about this life care concept.
>
> (Male, resident 8 years)

Further research is needed to reverse socially dis-integrative mechanisms and identify shared, re-integrative activities.

III.

INNOVATIVE APPROACHES IN GERIATRIC EDUCATION: PART 1

Objectives:

Upon completion of this presentation participants should be able to:

1. Identify the value of designing an interdisciplinary course on drug therapy that is based on a needs assessment process.
2. List at least two advantages, disadvantages and potential applications for developing contracts to provide inservice geriatric education via television to clinical site(s).
3. Discuss ideas, materials, and teaching techniques, which promote well-being and reduce stress for those in gerontology practice.

Authors:	Topic:
*David P. Elliott, Pharm.D. Pamela A. Harvit, RDH, MS West Virginia University	An Assessment of the Drug Therapy Education Needs of an Interdisciplinary Group Interested in the Elderly
Mary Ellen Simmons, RN, MSN Triton College	A Model of a Community College/ Nursing Home Partnership by Means of Instructional Television Fixed Services
Miriam Clubok, MSW, LISW Ohio University	An Approach to Teaching Stress Management for Gerontology Practice

*Denotes Presenter

An Assessment of the Drug Therapy Education Needs of an Interdisciplinary Group Interested in the Elderly

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Introduction

Health profession educators are frequently called upon to provide programs to groups interested in drug therapy for the elderly. What do these groups need to know? What are they interested in learning? An assessment of the educational needs and preferences of an audience can help to answer these and other related questions.

Purpose and Objectives

The purpose of the study was to measure the drug therapy education needs of a group of professionals with diverse backgrounds with a common interest in the elderly. The information gained by the study was to be used to design a ten hour course to be offered at an institute on aging.

The objectives of the research were to identify: the level of interest in attending a course on drug therapy in the elderly; the professional background of the group; the instructional methods preferred by the group; and drug therapy topics of interest to the group.

Methodology

The needs assessment consisted of developing, administering and analyzing a survey. A literature search was conducted and individuals interested in the elderly were interviewed to identify topics and issues of importance in geriatric drug therapy. The individuals interviewed represented the following disciplines: social work, nursing, pharmacy and community health education.

The literature search and interviews were used to design the content of the survey. The structure of the instrument (available on request) followed published recommendations for survey composition.[1] Minor changes were made in the survey content and structure based on a pilot test.

The final survey instrument was mailed to each individual who had attended the previous year's institute on aging. Means and standard deviations were calculated for the ordinal variables. A Chi-Square approximation (Kruskal-Wallis) was used to identify differences in preferences for instructional methods and program content among subgroups based on the respondents' professional training and work environments. A level of significance of $p < 0.05$ was assigned for the statistical tests.

Results

Two hundred forty-four surveys were mailed and 119 were returned (48.8%). The total direct cost (stationary, photocopying and postage but excluding personnel) was $59.78.

Of those who responded, 61% were planning to attend the institute where the course was to be presented. Thirty-four percent indicated that they would be interested in enrolling in the course whether they planned to attend or not. A variety of professional backgrounds were represented including administrators (8%), dieticians (2%), home health care providers (4%), nurses (4%), social workers (72%) and others (12%). The greatest number of respondents worked in long term care facilities and government agencies (53.8%).

The majority of the respondents indicated that they liked all of the methods of instruction listed on the survey instrument except self-directed activities and large group discussions. The remainder of the methods in decreasing order of preference were audio/visual, lectures, case discussions and small group discussions.

The respondents were at least somewhat interested (mean > 2) in all of the topics listed except treating insomnia and treating constipation. Of the seven topics with a mean > 2.5 (somewhat interested to very interested), three involved the use of drugs affecting the central nervous system (depression, dementia and anxiety) and three pertained to general topics on drug therapy in the elderly (drug interactions, adverse effects and changes in drug actions with age).

No significant differences were found among subgroups with regard to preferences for instructional methods (Kruskal-Wallis test). There were no significant differences in preferences for topics when grouped according to professional background.

Some differences did appear when the respondents were grouped according to their practice environments for 4 of the 16 topics (age related changes in drug actions, $P=0.032$; drugs used to treat arthritis, $P=0.017$; drugs used to manage dementia, $P=0.006$; drugs used to treat constipation, $P=0.030$).

Additional topics were suggested by 32% of the respondents. Comments and suggestions appeared on 17% of the forms returned.

The results of this needs assessment survey were used to construct a course that incorporated the instructional methods as well as the topics preferred by the group (Table 1). A variety of instructional methods were used. Case discussions were developed using the problem solving and decision making method which has been termed "guided design".[2]

Table 1: Course Outline

Topic	Format	Duration
Introduction	lecture	0.5
What are problems associated with using medications?	guided design	1
Drug therapy problems in the elderly	lecture	1
What drugs are commonly used in the elderly?	discussion	0.5
Drugs used to treat osteoporosis	lecture	0.5
Psychoactive medications	lecture	1
Drugs used to treat cardiovascular disease	lecture	1
Generic versus brand name products	discussion	0.5
Medicaid formulary	discussion	0.5
Drugs used to treat pain and arthritis	lecture	1
Poison exposures in the elderly	lecture	1
Over the counter products	lecture	1
Enhancing compliance with drug therapy	guided design	1

Discussion

This study demonstrates the value of conducting a needs assessment prior to planning a course that will be offered to an unfamiliar group. The results of this survey established the level of interest, the professional background and interests of a group who would be the likely recipients of the planned course.

Needs assessments have been reported in the medical and nursing literature, but not in pharmacy publications.[3,4,5] The survey is a traditional and relatively easily ccomplished approach to assess needs and preferences. The total direct costs of our survey was only $59.78. Return postage was not included which significantly decreased the cost of the project.[1] The return rate of 48.8% is gratifying considering that the survey was a single mailing without additional reminders or incentives.

The interest in the study group was quite high with 34% indicating that they would attend a course on drug therapy in the elderly. Advance knowledge of the interest level provided the rationale for developing a course.

The survey identified the study group as being primarily composed of individuals with limited knowledge about medications, thereby enabling the instructors to appropriately target the level of the content. Knowledge of the work environment of the prospective audience allowed instructors to appropriately narrow the focus of a program.

A variety of instructional methods can be employed to deliver a program. Of interest, the respondents in this study showed greatest preferrence for the audio-visual and lecture methods of instruction. Although efficient, these methods are probably the least effective in promoting the assimilation and application of information in professional practice. Methods requiring more active participation by the audience such as case and small group discussions would probably be accepted by this group and therefore were included in the program.

The topics selected for the survey were based on the medical literature and opinions of individuals with interest and expertise in the elderly. The results of the survey indicated that the group had clear preferences.

Topics that had a high level of interest were included. Topics with a lower rating were considered if the topic was likely an important issue based on the knowledge of the planning committee or literature reports. The lack of interest by the group may have reflected ignorance and therefore a true need. For example, a topic titled "Drugs used to treat cardiovascular disease" was presented even though the respondents did not indicate a high preference for the topic. The planning committee elected to include the topic in the course because cardiovascular drugs are the most frequently prescribed medications for the elderly.[6]

Conclusions

The survey was easy to conduct and inexpensive. The results of the survey enabled the instructors to target the content and structure the learning experiences of a short course on drug therapy issues in the elderly.

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TITLE: A Model of a Community College - Nursing Home Partnership by means of Instructional Television Fixed Services

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The nation's nursing homes have a new partner in quality. Through a grant from the W.K. Kellogg Foundation, nursing home administrators are working with six selected community colleges to develop ways of improving quality of care while attracting more nurses and care providers to nursing homes.

The "Community College - Nursing Home partnership: Improving Care Through Education" is a three-year pilot project involving Ohlone College (CA), the Community College of Philadelphia, Shoreline Community College (WA), Valencia Community College (FL), Weber State College (UT) and Triton College (IL).

Triton College, located in suburban Chicago, is working with three extended care facilities on this project, including Gottlieb Extended Care Unit, a 34-bed unit within Gottlieb Memorial Hospital; Norridge Nursing Center, Inc., a 315-bed facility providing skilled and intermediate care; and Westlake Pavilion, a 154-bed skilled nursing facility housing an Alzheimer's unit and respite care program.

The goals of the partnership are the development of nursing potential in long-term care settings through in-service education, and the redirection of associate degree nursing education to include active preparation for nursing roles in long-term care facilities. In particular, the Triton project is focused on refining the skills of staff already employed in nursing homes, educating faculty about geriatrics, and developing clinical rotations for students that include work in nursing homes.

Approximately seven percent of the older population in the United States resides in nursing homes. According to statistics, this figure will triple by the turn of the century, resulting in a nursing home bed shortage and a critical need for qualified personnel to care for these new residents.

Community colleges recognize this problem. As the nation's leading provider of registered nurses, community college educators are increasingly aware emphasis must be placed on long-term care education and clinical experience. In addition, continuing education opportunities must be extended to current nursing home staff.

Through close cooperation, the college and the three nursing homes have been able to identify specific needs unique to extended care facilities and develop various methods of delivery.

Triton College has been successful in providing educational programs to nursing home staff through Instructional Television Fixed Service (ITFS). This program delivery mode has proven to be effective with staff at all levels.

What is ITFS? ITFS generates from the Triton Campus and is received by the nursing homes via a series of microwave bands authorized by the Federal Communications Commission. The nursing homes are equipped with a special antenna which converts the microwaves to a regular television signal. If two-way interaction is desired, a phone hook-up can be used to connect the caller to the speaker(s) in the studio. Triton College's programs have included this component.

Following are listed the ITFS programs which have been offered to nursing homes by Triton's Department of Continuing Education Center for Health Professionals in conjunction with the Education Center on Aging: Successful Communicating: The Certified Nursing Assistant, A Valuable Person; Residents rights and Dignity; Resident Safety; and Infection Control.

The program for certified nursing assistants (CNA's) was a seven hour, seven part, one hour per each part, interaction program which fulfilled a two-fold purpose. One purpose was to assist the CNA in better communicating with patients, families, and other staff. The other was to increase self-esteem and feelings of worth in the CNA's. Marilee Culhane and Mary Ellen Simmons, registered nurses, and specialists in psychiatric and geriatric nursing, respectively, should be credited with the careful planning and implementation which made this program so popular with CNA's. The CNA's who participated were selected by the nursing home administrators. Moreover, facilitators were selected to assist at each of the two receiving sites. One of the facilitators was a CNA who was selected in recognition of her 12 years of dedicated employment at the nursing home. The facilitators led small group discussions for 10 minutes of each program. Pictures of the participants, both individual and groun, were shown on the screen throughout the program so CNA's could view themselves and each other. Faces were matched to voices as they interacted with each other on the telephone call-ins. One part of the program occurred during Halloween festivities. Triton faculty gave jack-o-lanterns filled with candy to each participant who, in turn, gave the candy to the CNA's who had worked during the program. Certificates of completion were given to each CNA. The CNA's and nursing homes had copies of the video tapes, which they showed to their families and peers.

This generated a lot of enthusiasm from other CNA's who wanted to participate in the program. Consequently, the program will be offered again. The last three programs were among a list of topics satisfying the Illinois Department of Public Health's (IDPH) program requirements. These programs were taped so they could be viewed by all shifts. More programs are scheduled to fulfill IDPH requirements.

What do participants have to say about these ITFS programs? Jenna Washington, Christine Norwood, and Jolly Peynolds, CNA's, Norridge Nursing Center, all stated that the programs gave them a better understanding of their patients. Martha Nwankna, CNA, Westlake Pavilion, stated, "The course was fun. It helps me to see that other CNA's had the same experience in working with residents that I have had." Barbara J. Keefner, R.N., wrote, "These type of meetings start the 'juices flowing'. They stir up ideas that were not given much thought in the everyday hustle. I learned very valuable information about drugs in the elderly." K. Gates, CNA, stated, "I am better at caring for my patients at Norridge because taking the Triton course by way of T.V. has sharpened my knowledge on the every day changes of the elderly. For example, I am able to recognize the symptoms of some of their illnesses before they materialize." There were many more testimonials given by participants, and they were all positive.

In summary, ITFS has proven to be a convenient, effective means of providing staff development programs to all levels of nursing home staff. The acceptance and support of the nursing home staff is essential. Moreover, careful planning by faculty will ensure successful implementation and outcomes of the programs. This means that facilitators must be trained for each receiving site, lesson plans and handouts carefully developed to meet the time schedules and objectives of the program, and recognition given to participants. Testimonials given by nursing home staff have been overwhelmingly positive, and they are asking for more programs. Hence, more IFTS programs will be offered by Triton to meet their needs.

AN APPROACH TO TEACHING STRESS MANAGEMENT FOR GERONTOLOGY PRACTICE

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Stress and the phenomenon of burn-out have long been recognized as contributors to physical and mental distress, low morale, decreased productivity, absenteeism, and high job turnover in a variety of occupations. This problem is especially serious in gerontological settings where many clients, suffering from chronic physical disease, organic brain syndrome, and depression are extremely demanding, complaining, dependent, and apparently unappreciative of service. Dealing with such clients can be upsetting for many workers, and often causes them to distance themselves from the client in order to avoid repeated unpleasantness. The negative feelings and guilt created by such situations make coping difficult and therefore increases the likelihood of stress and burn-out. The purpose of this paper is to present a format for a workshop designed to help workers in gerontological settings recognize and understand their feelings toward debilitated clients, identify sources of stress in both their professional and private lives, help them understand causes, symptoms, and effects of burn-out, and identify strategies for interventions that can avoid or minimize burn-out symptoms. This workshop and several variations of it have been presented numerous times for persons working in the entire spectrum of gerontological social service. Evaluations have consistently been extremely positive.

I. Introductions. It is recommended that there be no more than twenty-five participants in the workshop. Although this is an arbitrary number, experience has proven that in larger groups, fewer persons actively participate. It is also important to have a room with movable chairs to facilitate small group activities. After introducing onesself, and reviewing the workshop objectives and organization, participants can be asked to take out of their pockets, purses, etc., three items that represent things, persons, or activities they value. In small groups participants discuss these items and their meaning and become acquainted. The entire group reconvenes and each individual introduces another person commenting on the valued items. (10-15 minutes)

II. Small Group Exercise and Discussion. To begin a discussion of sources of frustration in work, particularly in gerontological settings, a variation of Edelwich's "planning board" exercise is helpful (1980, pp. 21-22). In this, participants, in groups of five or six, rank order various sources of strain and add others specific to their experience. The entire group then assembles, and each small group reports the rankings while the instructor tallys the results on a board or flip-chart. Participants are encouraged to cite examples from their work. (15 minutes)

III. Lecture/Discussion. At this time it is important to define burn-out and discuss the reasons for its prevalence in the helping professions.

A major part of the presentation should address stresses associated with geriatric patients and the effect of this population on staff. The group can be asked to identify characteristics of older persons that make them especially difficult, such as being demanding, frail, impatient, complaining, telling long stories, etc. The added problems of working with those who are depressed and confused can also be addressed. Participants can also be asked to identify characteristics of geriatric settings that make them especially stressful work environments, such as presence of conflict between various professional groups, presence of new technology, adjusting to staff turnover, etc. Societal and personal attitudes toward the elderly and toward death and disease should be mentioned. Information on the stages of burn-out should be presented. Participants can be asked to identify and/or comment on staff behaviors that occur as stress builds. They can list how the agency may be affected (lower productivity, poor image); how the individual worker may be affected (illness, anger, family problems); and how staff behaviors may affect the client (staff is indifferent, cynical, infantalizes client, becomes careless with regard to confidentiality or privacy). Some helpful sources for developing this section include Edelwich (1980), Garfield (1979), Heine (1986), and Pines and Aronson (1981). (30 minutes)

IV. Film. "Burn-out", color, 26 minutes, University of Wisconsin, AV Center, 1705 State St., Lacrosse, WI 54601. This is a humorous, fast-paced film showing social service persons affected by burn-out. It points out symptoms and some interventions. In addition to being entertaining, it stimulates the discussion to follow on specific intervention techniques.(30 minutes)

V. Interventions. At this point a range of interventions are presented and discussed, with emphasis on developing awareness of the problem, taking responsibility for action, and developing new tools for coping. Many specific suggestions are shared and can be easily compiled utilizing the sources cited in the reference list. Interventions can be grouped into two main categories: those that require altering the environment, and those that require improving one's own coping ability. In many geriatric settings, where changing the environment may be especially difficult, techniques for personal coping need to be stressed. (30 minutes)

VI. Self-Analysis and Plans For Change. Several options exist for helping participants examine their own lifestyles and identify the general degree to which they are burned-out, the areas in which change is needed, and appropriate interventions. Pines and Aronson (1981,pp. 37-38) include an inventory to identify burn-out that is easy to use and brief. After using this, participants could be asked to identify their top three ranked sources of frustration from the first exercise, and now identify appropriate interventions for each. If more time is available, however, the StressMap by Orioli and Jaffe (1987) is both fun and useful. This activity identifys one's degree of stress in twelve

areas: work changes, work pressures, work satisfactions, personal changes, personal pressures, personal satisfactions, self-care, direct action, support seeking, situation mastery, and time management. Once trouble spots are identified, one can begin planning for intervention. If time permits, an excellent group problem-solving exercise can be used, as described by Edelwich (1980, pp. 227-230). (25 minutes)

VII. Conclusion. Before participants leave, they are asked to remember the three items they took out in the introductory exercise. It is pointed out that these represent what is really important in each person's life, and by remembering these, especially when experiencing stressful events, one can maintain a more realistic perspective in life. (5 minutes)

The workshop as presented here has been planned for a two and one-half hour period. With some adaptations, it can be successfully given in one and one-half hours, and can easily be lengthened to three hours. A 10 minute break should be scheduled for a three hour session. When there is sufficient time, it may be possible to include some relaxation exercises during the section on interventions. While there are many of these to choose from, a relatively inexpensive and readily available audio tape may be obtained from any local chapter of the American Lung Association. This tape takes about 25 minutes. In addition, Maslach (1982, pp. 150-155) includes some excellent exercises on deep muscle relaxation and imagry training.

Understanding and reducing stress in social service results not only in improved patient/client care, but also in healthier and more productive workers. It is hoped that the ideas and resources described here will be helpful to those who wish to present a program for workers in their agencies or communities.

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III.

INNOVATIVE APPROACHES IN GERIATRIC EDUCATION: PART 2

Objectives:

Upon completion of this presentation participants should be able to:

1. Describe at least two pedagogical procedures to meet humanities requirements in baccalaureate programs while introducing students to images of aging.

2. Compare and contrast American and Japanese attitudes and behavior toward the care of older persons.

3. Discuss the reasons for utilizing humor when teaching sensitive topics and describe three techniques for incorporating humor into the curriculum.

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Topic:

Prolegomenon to the Study of Aging

Teaching Intercultural Attitudes to Aging Through Literature

Humor as an Innovative Method for Teaching Sensitive Subjects

PROLEGOMENON TO THE STUDY OF AGING

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To earn a baccalaureate degree at most universities in the United States certain "general education"--usually humanities--requirements must be satisfied. Students, and some of their advisors, have been known to murmur that time and tuition could be better spent by taking more courses in their majors rather than "wasting time" on courses that have no immediate relevance. While this position is not really defensible, it is to some extent understandable, given the pragmatism of today's student. (I've had a number of discussions with my own career-oriented, college-aged children on the subject.) What is needed is a course that would satisfy general education/humanities requirements and at the same time provide students with substantive subject matter in their major subject area. I would offer the following suggestions for developing a humanities course that would serve the need of gerontology majors.

STEP 1. Begin with your own degree programs. Know your department's requirements and your institution's. If it is not possible to add a new course or to adapt existing courses, your only choices, obviously, are to quit or fight. (But that's a topic for another paper.) If, however, mechanisms for change are available, you must understand how they operate. Are decisions made on the departmental, college, or university level? How many approvals must be secured? How long will it take to get the course approved? (Don't plan to offer a course in the next semester if it takes a year to get approval.) Don't waste time fighting the system; work with it.

STEP 2. Assuming that a course can be added to the curriculum, your next step is to find a colleague in a humanities department who might be willing to work with you on developing it. Take the direct approach and contact department chairs with a general description of the project; if you're at a smaller school, or have less faith in department chairs, contact the faculty directly. Traditionally, literature courses are the domain of English Departments, so you may wish to start there. But don't ignore Philosophy, Theology, Communication, or Language Departments. In fact, at this stage you have the option of deciding whether your course should be interdisciplinary or multidisciplinary.

STEP 3. When you've found a kindred spirit, or at least a willing

partner, discuss the proposed course in detail. Determine its objectives and the pedagogical procedures you will follow. (Unless one of you has done work on this topic before, DO NOT ATTEMPT TO SET UP A SYLLABUS AT THIS TIME. You will discover that the process of selecting works can be as valuable as the final list.) Determine the level of the course. Is it introductory or advanced; will it be limited exclusively to gerontology students or open to students in any major? (The student mix can have a dramatic effect on way the class responds.) Determine the types and number of assignments the students will be expected to submit. Will students be graded on form or content, or both? Will split grades be assigned? Who will do the grading? Will there be a master teacher or will teaching responsibilities be equally shared? This is the shake-down stage of curriculum development, where every problem must be anticipated.

STEP 4. Now write to colleagues in as many departments as you deem suitable--asking them for bibliographies, reading lists, or suggestions on the topic of aging in literature, aging in film, aging in popular culture. You will discover a remarkable willingness on the part of your colleagues to share ideas. (I surveyed 14 members of our English Department and received 11 replies, with an average of 6 works cited per response, including a complete syllabus for a course entitled "Images of Maturity in the Short Story.") These responses will serve as the basis for your own syllabus.

STEP 5. Wait for the replies, but don't hesitate to nudge if necessary. (This is a good time for you to develop your own bibliography of gerontological readings to be given to students, and your partner.)

STEP 6. When you have a sufficient number of responses, begin cataloging them. Determine which names or titles are repeated frequently, which are totally new, which are outrageous or banal. (In my own survey the works frequently repeated were Tennyson's "Ulysses," Hemingway's The Old Man and the Sea, and King Lear, but the same survey produced works I had never heard of.) Wherever possible begin categorizing the responses by medium, message, or genre. (The humanities member of the team should be of great help here.)

STEP 7. With a working list of titles now available, read (view, etc.) and analyze the works to determine why your colleagues selected them. This step can lead to a number of interesting conclusions. You'll discover the biases of the artists, certainly, for literary greatness doesn't necessarily mean complete awareness of gerontological principles. But you'll

discover the biases of your colleagues as well. T.S. Eliot's "The Love Song of J. Alfred Prufrock," written by a 27 year old, depicts a character of indeterminate middle age, yet a number of faculty members insisted on including it on their lists of works on aging. Another included "Bartleby the Scrivner" on his list because the narrator announces at the beginning of the story, "I am a rather elderly man." Clearly these examples show that faculty--at least faculty in disciplines other than gerontology--need sensitizing to real world attitudes and facts. This is a sensitive stage in the formulation of a syllabus, for theory and practice can collide if care is not taken to have parameters established. In fact one way to structure the course is on the basis of myth versus reality: the artists' myths of the aged versus the reality of the aged, popular myths (including the misconceptions of educated people) versus real-life situations. A second way to structure the course is on the basis of topic: youth versus age (Frost's "The Death of the Hired Man," for example), the aged as power brokers (King Lear covers this and many other relevant topics), sexuality and the aged (Toni Cade Bambara's "My Man Bovanne" is a serious treatment, but you may wish to counterbalance it with an outrageous work like Philip Jose Farmer's "The Henry Miller Dawn Patrol"). An anthology like Sharan B. Merriam's Themes of Adulthood Through Literature (New York, 1983) can give you an idea of how others have organized similar ideas.

STEP 8. With a working list of literature or film in place, develop the gerontological perspectives that you hope to apply to the works. Share this with your humanities colleague. Provide reading lists of appropriate sources (perhaps even the lists that you would expect the students to read), making certain that both of you agree with the direction of the course and that an adversarial environment does not develop.

STEP 9. Develop the syllabus, being certain that each of you understands what is to be accomplished.

STEP 10. Test the completed syllabus. Share it with colleagues in your own department as well as those in the humanities disciplines. Ask for frankness (but don't be dismayed when you get it). Plan a public presentation on one work (every institution has a lecture series looking for volunteers); a one hour lecture can often reveal gaps or flaws in logic. Offer a comparable presentation based on several works to area professionals (you might even structure it as a seminar and charge admission, offering some form of continuing education credit), or to community groups or senior citizen groups (who will be painfully frank). If your institution offers an

ELDERHOSTEL or comparable program, test it there as well. The key to this step is test, test, test. Reach every audience you can, for all feedback is important.

The steps listed here are intended to give you a starting point for the development of a literature course. You can apply the same principles (with your own additions, wherever necessary) to courses in film or popular culture. If you follow these ten steps you can feel secure that you have taken appropriate measures to develop a course that will satisfy the needs of your students, achieve a high level of academic integrity, and will be enjoyable to teach.

(For a list of works submitted to me by the faculty in our English Department, write to A.J. Solomon, Office of Continuing Education, Dexter Hanley College, University of Scranton, Scranton PA 18510.)

TEACHING INTERCULTURAL ATTITUDES TO AGING THROUGH LITERATURE

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The main focus of this study is to examine intercultural attitudes of Japanese and Americans in regard to the treatment of older people (particularly older parents) in each culture.

The Japanese theme of self sacrifice and abandonment of the elderly will be traced through folklore and literature, and contrasted with contemporary values and attitudes in Japan and in the U.S. To reinforce this comparison, two survey instruments were developed, one for Japanese college students and the other for American students to ascertain their feelings about care of the elderly, responsibilities of caregiving, and subjective reactions to aging. Results of the surveys will be discussed and serve as a point of contrast with earlier survey data and contemporary research studies.

Japan is the world's most rapidly aging society. In a 1981 study done in Tokyo, data suggested that two thirds of the frail elderly were in the care of the families and three fourths of the aged lived with their children or grandchildren. However, the "Super-old", as they are called, are experiencing a change in the attitude of the young, in terms of providing responsibility for care, and for living in close proximity to one another.

A 1988 survey conducted by the Japanese Ministry of Health and Welfare stated that 81% of the 6,000 men and women surveyed (ages 18 - 34) preferred a single independent status for their lifestyle. When asked whether they wanted to live with their parents, only 62% of the males and 40% of the females responded affirmatively--a 10% decrease for males and a 17% decrease for females from a survey reported five years earlier. This is in contrast to the ethic of filial piety observed in Japan traditionally, in spite of conflicts present in a parent-child relationship (Palmore and Maeda, 1985). In the early 1980's 20% of all households were "kin-linked" (Fukutake, 1982), demonstrating a closeness and traditional loyalty between the generations living together. Long's (1987) research suggested that a majority of Japanese elders still prefer to live with their married children even though industrialization and job availability have split the family, with more women

seeking careers outside the home. In addition, Japanese young women appear to be more assertive about marriage and caregiving responsibilities towards their elders (Japan Economic Planning Agency, 1982).

Like Japan, America has become more sensitive to caregiver responsibilities and housing requirements for the elderly. By 1980, 40% of Americans in their late 50's had a surviving parent, as did 20% of those in their early 60's, 10% of those in their late 60's, and 3% of those in their 70's (Brody, 1985). Parent care, according to Brody, stimulates the anticipation of the family break-up and the potential for dependence on younger children.

Do family caregivers in both cultures view their responsibilities to their parents in similar ways? Can an examination of the literature about family caregiving present a realistic view of how cultural attitudes affect the treatment of the elderly?

The Japanese legend of OBASUTE and its reappearance in various literary forms seems to suggest that a strong moral value in Japan is tied to sacrificing oneself for the good of a larger group, i.e., the family. Underlying this theme is the assumption that when a person becomes 60 they are no longer a productive member of society and should bring about a swift ending to life so that no further burdens will be placed upon the family for their support.

The value of life becomes dependent upon age and productivity - a combination of terms which many Americans find difficult to accept. Consequently, a growing number of authors have begun to suggest that the elderly be regarded as a surplus group with a moral duty to accept the ending of a life well lived, therefore avoiding the squandering of extra resources of all kinds to sustain their life. In America, anxiety about parental care-giving is often linked to the adult children's anxiety about their own mortality (Troll, 1986).

The Japanese culture encourages dependency and close familial relationships, therefore making it appear natural that bonds between parent and child remain strong. However, in America, the belief in individuality and in independence outside of the group setting may be creating an easing of the feeling of filial responsibilities toward older parents. "The best things to give

your children are roots and wings." - a common saying that appears quite different from the traditional closeness which has been fostered within the Japanese family in the past.

Although traditional religious values about caregiving continually surface in Japanese literature, present day interviews and research suggest that many Japanese women are expressing their desire to free themselves of family ties (Campbell and Brody, 1985). Although overt acknowledgments of the elderly are shown in the Japanese culture through language, behavior, special privileges and holidays, many young people (through survey responses) suggest that they are not going to allow themselves to be subjected to traditional roles in caring for the elderly as they have been in the past.

Ninety-five percent of 71 Japanese college students who completed an original survey were familiar with the legend and moralistic theme of OBASUTE. Thirty-eight students completed the survey in the United States while 29 additional students completed it in Japan. Ninety-nine percent of the total sample responded that older people should live at the end of their lives "with their family." "The family" was also the preferred response (100%) of subjects in answer to "Who usually takes care of an older person when the person is no longer able to work?" Just over one third of the respondees had an elder living in their family home. However 67% of the students agreed they would place an elder in a nursing home if they were unable to care for that person, even though 72% of the students had never visited a nursing home in Japan. The three most frequent responses to the question of what conditions might prevent an elder from wishing to enter a nursing home, were family obligations (25%), family alienation and lonliness (24%) and financial considerations (18%). When asked what elders "should do for the rest of their lives," the preferred answer was "find something to do" (46%) (hobbies, gateball, etc.), "relax" (37%) and "have family care (17%).

Forty-six American students also completed a survey. Thirty-five percent responded that the elderly should live with "family" at the end of their lives, 29% answered "with other elderly", and 30% answered "in their own place." Sixty-one percent answered that "the family" takes care of non-working elderly, versus 20% of those sampled who answered "nursing homes" usually

do this. A majority (61%) had visited a nursing home and 74% agreed to put an elder into a nursing home if unable to care for them. Conditions preventing an older person from wanting to enter a nursing home were selected as fear (24%), isolation and loneliness (29%), finances (15%) and traditional family ties (15%). In responses to the question "What should happen to an old person for the rest of their lives?", 24% answered "Have family care," "Relax and enjoy benefits worked for" (46%) and "occupy themselves with hobbies and projects" (30%). Only 11% of American respondents have an older person living in the family home. One hundred percent of the American students sampled selected the Japanese culture as the one which treats the elderly more positively than their own, using the words "respect" (91%) and "wisdom" (26%) to describe their perceptions of Japanese attitudes toward the elderly.

American students' attitude toward today's older people as requested on the survey was "Positive" (57%), "Neutral" (41%) and "Negative" (9%). Their personal attitudes about "getting old" were more negative than positive; with an equal percentage (33%) of students admitted to being fearful or resigned about growing old while 26% expressed "dislike" for the idea. Their "greatest fears about growing old" (in order of frequency) included "Death and dying" (26%), "Being alone" (22%), "Losing independence" (19%), "Loss of physical appearance" (13%), and "Loss of mental capacities" (6%).

Comparing these survey responses to attitudes in the OBASUTE literature and in U.S. literature assigned, students can be encouraged to discuss their feelings and responsibilities toward the aged, and in turn, can acquire an intercultural perspective on aging concerns.

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PURPOSE

The geriatric education curriculum recommendations and guidelines for allied health, dentistry, medicine, nursing, pharmacy and social work require the inclusion of training on such subjects as fear of aging, death and dying, grieving, and suicide in the elderly. These subjects are often viewed as sensitive by both faculty and students.

The purpose of this paper is to legitimize the use of humor in the teaching of sensitive subjects and to provide suggestions for ways in which humor can be incorporated into the geriatric education curricula in the health care disciplines. Specifically, the geriatric education curriculum recommendations and guidelines that apply to the inclusion of sensitive subjects in the health care disciplines are reviewed; the theoretical basis and research results that support the use of humor are documented; the benefits of using humor are outlined; and, suggestions to enable faculty to incorporate humor into the geriatric education curriculum are provided.

In order to meet the needs of the growing older population, health professionals must address sensitive issues. Twelve percent of the US population is age 65 and older and utilizes more than 33% of physicians' time, represents 40% of acute hospital admissions (NIA, 1987), and consumes about 31% of all prescription medications (Baum et al, 1984). White males age 65 and older are at the greatest risk for suicide of any other age group (Bromberg & Cassell, 1983). Seventy-five percent of the elderly who kill themselves see a physician one month prior to completing suicide (Kirsling, 1986; McIntosh, 1987). Home health services for older persons are steadily increasing, and nursing home use has nearly doubled in the past 20 years (ANA, 1987).

RECOMMENDATIONS AND GUIDELINES

The message is clear in the recommendations and guidelines for the health care disciplines that sensitive subjects such as fear of aging, death and dying, grieving, and suicide be included in the geriatric education curriculum. Guidelines for geriatric medicine fellowships (JAGS, 1987) include the directive to identify "Psychosocial aspects of aging including housing, depression, bereavement and anxiety." Recommendations for graduate medical education include the identification of feelings about the aging process, death and dying (Long, 1982; Robbins & Beck, 1982).

The standards and scope for gerontological nursing practice (ANA, 1987) indicate the need to enable patients and families to cope with behaviors associated with aging, chronic illness, death, and the grieving process. Increased attention is suggested in the areas of depression, suicide in the elderly, and the grieving process associated with losses (NIA, 1984). Professional organizations for long-term care consultant pharmacists and hospital pharmacists include specific training on death and dying in their certification standards (ASCP, 1981; ASHP, 1972).

Geriatric dentistry (AADS, 1988) recommends that the concepts of death and dying and the grieving process be discussed, and that personal concerns or fears of aging, death, and dying be recognized, accepted, and controlled. The disciplines of social work and allied health also cite the need for curricula on psychosocial aspects of aging, including care of the terminally ill, death, and dying (Kim et al, 1986; AOA, 1986).

Each of the health care disciplines states the need to include sensitive subjects in the geriatric education curriculum. It has been noted that jokes are made about those things most feared, and that laughter allows distancing, a release of tension, and relief (Leiber, 1986). Given this premise, one method of presenting sensitive subjects would be through the use of humor.

THEORETICAL BACKGROUND

The theoretical background of humor is varied and controversial. Humor is based on such theories as superiority, incongruity, and tension reduction. The control of group behavior, basic attitudes, political repression, and coping also are linked to humor.(Lefcourt & Martin, 1986; DeSpelder & Strickland, 1983; Goldstein & McGhee, 1972; Morreall, 1987; Nahemow et al, 1986; Obrdlik, 1942; O'Connell, 1968). Although portions of each of these theories may explain the use of humor for teaching sensitive subjects, the theoretical perspective that relates humor to tension reduction most closely applies.

The tension reduction theory of humor has also been identified as the relief, arousal, affective, liberation, or freedom theory (Lefcourt & Martin, 1986; Liechty, 1986; Morreall, 1987). Philosophers and theorists including Freud, Mindness, and Niebuhr (Liechty, 1986) have viewed humor as a mechanism for releasing fears and constraints associated with difficult situations. The belief that we laugh to release internal tensions and cope with our misfortunes is one theoretical basis for explaining humor. One primary role of humor is to aid in the defense against the grim realities of life. As James Thurber reportedly once said, "Humor is emotional chaos remembered in tranquility."

BENEFITS OF HUMOR

A number of empirical studies have provided evidence that a sense of humor indeed can reduce stress, decrease pain, and promote health (Labbot & Martin, 1987; Lefcourt & Martin, 1986; Martin & Dobbin, 1988; Nezu, Nezu, & Blissett, 1988; Tooper, 1988). Anecdotal evidence is found in the well known autobiographical account of Norman Cousins (1979) who used humor therapy to help overcome collagen disease.

Humor is used appropriately in the health professions to diminish discomfort, manage delicate situations, and enhance communication with patients and students. It also may be used as a mechanism for establishing relationships, relieving anxiety, and releasing negative emotions (Robinson, 1970, 1977). Humor helps patients to adjust to hospitalization and the "sick role", to cope with depression (Leiber, 1986), and to negotiate the acceptability of potentially difficult topics of discussion (Warner, 1984).

Medical humor often is used by physicians and other health care providers as an effective coping mechanism for the stressful life-and-death emotional situations of the health professions. Although the humor may be seen as callous behavior to some, it enables many medical professionals to cope with the stresses of their work without diminishing their medical competence or decreasing their concern and care for the patients.

Closely related to medical humor is gallows or graveyard humor. This humor enables the reduction of anxiety and allows distancing from one's own mortality (DeSpelder & Strickland, 1983; Morreall, 1981). Gallows humor is the humor of survival. It enables defiance, offers emotional escape, and offers a mechanism of control (Thorson, 1985). Gallows humor is said to be "...an unmistakable index of good morale and of the spirit of resistance..." (Obrdlik, 1942).

When overwhelmed by the seriousness of illness or threat of death, humor can be used to cope with the situation or temporarily avoid dealing with it. Gallows humor, through false bravado or great courage, makes it possible to deny the importance of death and to accept death as a part of life. Laughing at death provides a triple pleasure--the joke, laughter at death's expense, and the fraternization with death (Mikes, 1971).

Humor has been shown to reduce stress and anxiety and to enhance the ability to cope with the spectrum of situations from uncomfortable to life-threatening. Humor also has been found to be of benefit in educational settings. Studies are accumulating evidence indicating that humor is a desirable characteristic of teachers and of teaching (Hunsaker, 1988; MacAdam, 1985; Powell & Andresen, 1985; Watson & Emerson, 1988; Ziv, 1988).

The benefits of humor as a teaching tool include establishing a relaxed, positive atmosphere conducive to better learning; promoting increased comprehension and retention; holding attention and aiding cognitive development; managing undesirable behavior; building self-confidence; and enhancing the lives of both students and faculty.

MacAdam's (1985) summary of research on humor and teaching supports the belief that humor is often used in higher education and best used when it is spontaneous, open, and honest. Instructors are encouraged to model positive humor and to view humor as both a learning strategy and an intervention technique in patient care (Watson & Emerson, 1988).

Timing, receptiveness, and content are three criteria for determining the appropriateness of humor (Leiber, 1986). Humor never should be used to ridicule, embarrass, mock, or exploit others. Racial, sexist, ethnic and ageist jokes never are appropriate. The intent is to laugh <u>with</u> another or at ourselves--not to laugh at the expense of another.

The many benefits resulting from the use of humor in educational settings lend credibility to the use of humor in teaching sensitive subjects. Little is known about the use of humor in professions that deal with death (Nahemow et al, 1986), and little has been written about using humor to teach about aging, death and dying, grieving, and suicide in the elderly. However, the literature does provide general suggestions for incorporating humor into teaching. With a bit of creativity and daring, these suggestions can be applied to sensitive subjects.

HUMOR IN TEACHING SENSITIVE SUBJECTS

The educational literature recommends establishing an atmosphere of humor; keeping a humor diary; sharing humorous items, funny stories, jokes, cartoons, humorous quotations; writing limerics, last lines of limerics, comic verse, captions for cartoons, punchlines for jokes, monologues; exaggerating problems and brainstorming solutions; and creating new uses for common objects (Baughman, 1979; Highet, 1958; Hunsaker, 1988; Morreall, 1981; Watson & Emerson, 1988).

The application of these activities to geriatric education first requires the decision to include humor. Once that decision is made, attention must be paid to timing, receptiveness and content. Introduce humor into the course early and be alert to opportunities to reveal the lighter side of serious situations. Indicate receptiveness to humor and become familiar with the unique sense of humor of each student.

Content can include funny stories, jokes, humorous quotations, cartoons, poems, puns, personal experiences, films, audio and video recordings, etc., that can be used to illustrate the primary points of the course material. The humor section of bookstores and the newspaper comics are excellent places to begin the collection. Resources for becoming more adept and comfortable with the use of humor include Blumenfeld and Alpern (1986), The Smile Connection, and Ewers et al (1983), Humor: The Tonic You Can Afford. Remember, presenting humorous material is a skill that can be learned through practice.

Once the humor resource collection is underway, develop a filing system that is indexed and cross-referenced to save time locating materials. Brainstorm ways that these materials and other humorous activities can be included in the course and incorporate these ideas into the lesson plans. Tailor the humor to the subject matter so that it exemplifies the point as well as entertains. Try different approaches to determine comfort levels, assess known talents, discover underutilized talents, and increase creativity.

Assign students to bring and share with the class humorous experiences, stories, cartoons or jokes about the topic. Require that students in practicums keep a daily humor journal to help them identify what they find to be funny and to identify situations in their work where humor could be used as a therapeutic intervention. Request that they find at least one thing to laugh about with each patient during each visit and then share the experience with the class. The possibilities are unlimited. This is the good news.

The bad news, according to Morreall (1981), is that students become curious, playful and creative; they experiment with ideas and ask difficult questions; and, they realize that there are different points of view. This requires of the instructor more effort, flexibility, freedom, and open communication. However, if this is the worst that can happen, then there is certainly a place for humor in geriatric education.

SUMMARY

The use of humor to teach sensitive subjects is an excellent way to promote a nonthreatening, positive environment that enhances learning. Timing, receptiveness, and content enable appropriate use of humor. Subjects that otherwise would be uncomfortable and threatening become manageable through the distancing and control inherent in humor.

HUMOR AS AN INNOVATIVE METHOD FOR TEACHING SENSITIVE SUBJECTS

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IV.

FACULTY DEVELOPMENT MODELS: PART 1

Objectives:

Upon completion of this presentation participants should be able to:

1. Identify three major steps in the process of assessing any curriculum in relation to geriatric/gerontological content.
2. Evaluate the applicability of integrating specific content areas into courses to the philosophical and theoretical concepts of overall curriculum design and integrity.
3. List the educational and financial benefits of utilizing a faculty retiree as clinical faculty in a university/community collaborative contract.

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Topic:

Assessing Curriculum Relative to Aging Content

Incorporating Geriatric and Gerontological Content into the Baccaulaureate Nursing Curriculum

The Faculty Retiree as a Resource for University/Community Collaboration

*Denotes Presenter

ASSESSING THE CURRICULUM RELATIVE TO AGING CONTENT

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The health professions exist to meet the health needs of society. The changing profile of the health care consumer establishes the older adult as a distinct group requiring attention in the academic arena. Academic programs have the responsibility for preparing graduates to work with the health care needs of an aging population. The purpose of this paper is to delineate the process by which one faculty group responded to the need to change a baccalaureate nursing curriculum in relation to geriatric and gerontological nursing content. This process can be applied to other educational programs preparing health care providers at the entry level of practice, which include care of the older client.

The fastest growing portion of the 65+ group are those who are 75 and older. Projections are that by the year 2030 this group will make up more than 50% of all those who are 65 and older. Data show that the incidence of chronic conditions which limit activity and function increase with age. Consequently, the need for health care services increases also. In 1986, this population accounted for 31% of total personal health care expenditures (AARP).

Although the care of the sick and frail elderly has always been the responsibility of the nursing profession, nursing education has been slow to respond to the need for preparing nurses to care for increased numbers of elderly. Studies by Brower (1981) and Tollett (1982) and others have revealed the reluctance of nursing schools to include geriatrics and gerontology in the basic curricula at all levels of nursing education. It is imperative that academic programs prepare graduates for dealing with complex health care needs of older adults. Recently more and more schools have been making a concerted effort to include gerontological content as an integral part of the curriculum (Solom, et al).

The School of Nursing at East Tennessee State University (ETSU) recognized the need to prepare graduates with the skills needed to care for increasing numbers of older adults in the health care system. A review of the curriculum was undertaken to determine strengths and deficits relative to gerontological nursing content. This curriculum study was given impetus by the establishment of a Center for Geriatrics and Gerontology at the University and subsequent participation in the Ohio Valley Appalachia Regional Geriatric Education Consortium. A task force was established to study curriculum offerings for students in the generic baccalaureate, RN-BSN, and the associate degree nursing programs.

The task force consisted of a small group of nursing faculty who had indicated a strong interest in aging and gerontological nursing. To begin the work, specific objectives were outlined: 1) identify the geriatric and gerontological content currently being taught in the present curriculum, 2) determine if this present content was adequate to prepare graduates who were knowledgeable about the aging process and possessed appropriate clinical skills to provide care to older adults, 3) make recommendations for curriculum changes based on results of the curriculum review, and 4) review library and instructional media resources relevant to aging and nursing care of the older client.

The task force, through a review of the literature, identified specific requisite knowledge of the aging process expected of graduates of undergraduate nursing programs. The ANA Standards of Practice for Gerontological Nursing were utilized as a framework and examples of competencies for each standard were outlined. In order to determine the extent to which the existing curricula addressed the issue of aging and nursing care, a survey instrument was developed and distributed to the faculty (see Table 1). In the questionnaire, faculty were asked to identify areas of competency in geriatric and gerontological nursing which they included in their respective courses throughout the total curriculum. The approximate amount of lecture time spent on each standard and/or competency was also noted.

Thirteen courses in the School of Nursing included geriatric and gerontological content. Out of the 13 courses, faculty identified a total of 96 1/2 hours was spent discussing concepts related to gerontological nursing. This would amount to the time one would spend in a 6 hour course! The task force members recognized that the information on the survey was faculty's estimation of time spent on gerontological content rather than true clock time. The evaluation of this survey indicated content in gerontology was presented in a spurious fashion, depending on the commitment of a specific faculty member to the issue of caring for the aging. Although the task force had given a time limit for the return of the survey forms, the faculty were slow to return them. In fact, it took all of one semester and it was discovered that as the faculty had become sensitized to the whole aging and curriculum content issue, they were including hours and minutes of gerontological content in their courses which they planned to teach the next semester. Rather than return the forms to the faculty for revision, it was decided to accept the results at face value with the understanding of how they were filled out and accepting the fact that part of the difficulty could be the survey instrument itself. Although competencies were listed under each ANA Standard, they were non-inclusive and faculty were asked to add specific competencies

they felt necessary for their particular course....no faculty person added a competency. The survey was helpful, however, in identifying weaknesses in curricular offerings relative to particular competencies in caring for the older adult. Specific areas of weakness noted included no long-term facility care experience, no planning for a chronically ill client in a long-term care facility, no mention of multidisciplinary approaches in caring for the elderly and no differentiation of physical changes noted in the young adult from the older adult.

In order to find out more about current clinical experiences relative to elderly clients, an additional survey (see Table 2) was developed to determine the age of clients assigned to the students. The purpose of this tool was to compare the number of older adult patients with the patients from other age group categories cared for by students in the School of Nursing. The tool also asked for the primary diagnosis of the patient. This was done in order to identify the most common diagnoses encountered by the older adults in our local population.

All faculty in the School of Nursing were asked, on a voluntary basis, to assist with the collection of data requested on the survey. The survey was conducted over a seven week period and of 26 faculty, 15 participated. During the semester students were assigned to six practicums in eight health care settings. The settings included both acute health care facilities and community health facilities where clients of all age groups were found.

Results of this survey indicated that approximately 50% of the total number of clients cared for by all students in all curriculum options were 50 years of age and older. A summary of these survey findings is found in Table 3. These findings validated the impressions of the task force that the clients cared for by the students in their clinical practicums are primarily in the older age group. Since clients in the survey included all age groups rather than just those limited to the adult age group, the 50% figure is slightly less than anticipated. Another major weakness of this survey was the limited participation of faculty. Participation was on a voluntary basis with only 57% completing the surveys. Maternal-child faculty had a higher ratio return rate of their surveys compared to those faculty in the adult clinical courses. Another weakness was the time frame. Data was collected for only 7 weeks.

It is important to note here that the curriculum with which the task force was working was an integrated curriculum. Developmental theory was a thread that was to be emphasized throughout each course. When, for example, the lesson topic was hypertension, the

discussion was to focus on nursing interventions related to hypertension as it might effect a young child, the pregnant woman with hypertension, as well as hypertension in the older adult. However, objectives for each course were quite broad and were subject to individual faculty interpretation.

As previously stated, the collection of data took place through the two survey tools and through faculty interviews. The informal interviews with faculty took place when the faculty were invited to the task force meeting to discuss gerontological course content and during faculty curriculum meetings. It was noted those faculty committed to the inclusion of gerontological nursing content provided the content in their classes, just as those faculty whose primary interest was the young spent more time including concepts relating to that age group. These interviews provided the task force with two specific items of information: 1) commitment to content by the course instructor influences content covered in a course, and 2) broad course objectives allow for broad interpretation.

Specific recommendations made by the task force to the School of Nursing Curriculum Committee were as follows:

1. Each course should have specific objectives which address the aging process and related nursing care.

2. Specific courses/credit hours in aging and gerontology must be offered within the nursing curriculum.

3. Library and instructional media resources in gerontological nursing and age related topics should be increased.

4. Increase faculty members' sensitivity to age-related issues through attendance at workshops, seminars, etc.

5. Increase School of Nursing faculty's participation with the Center for Geriatrics and Gerontology through consultant activities, committees, research, etc.

The process discussed here was one faculty's method for assessing the content related to aging in their curriculum. A task force conducted a library search to determine the necessary age-related content that should be in the curriculum, conducted faculty interviews, and utilized two survey tools to determine what age related content was actually being presented in the curriculum. Although the survey tools had not been tested for validity and reliability, they did allow the task force to identify the strengths and weaknesses related to aging content in the curriculum.

Suggestions to other educational programs who want to assess their curriculum for age-related content would include:

1. Raise awareness of all faculty to age-related issues.

2. Obtain administrative support.

3. Identify competencies/specific behaviors related to aging based on Standards of Practice for your particular profession.

4. Review each course in the curriculum for gerontologic content. Pinpoint gaps and overlaps.

5. Design a survey tool to meet your particular curriculum needs.

6. Assess library and instructional media resources.

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TABLE 1. Curricular Survey Forms

Faculty _____ ___ADN ___BSN ___RN-BSN*

Requisite Knowledge:	Teach	Course	Class Time Hours
1. _____	____	_____	_____
2. _____	____	_____	_____
3. _____	____	_____	_____
Standards:			
Examples			
1. _____	____	_____	_____
2. _____	____	_____	_____
Additional Topics:			
_____	____	_____	_____

* Bridge course

TABLE 2. Clinical Experience Survey Form

Faculty _____

Week _____ Clinical Site _____ Course _____ AD ___ BS __

Student _____

Client's Primary Medical Diagnosis:

_____

Client's Age:

(please circle)

0-12 mos.
12 mo.-2 yr.
3-5 yrs.
6-12 yrs.
13-18 yrs.
19-35 yrs.
36-50 yrs.
51-64 yrs.
65-75 yrs.
76-85 yrs.
86+ yrs.

TABLE 3. Ages of Assigned Clients Survey

Age of Clients	Number	Percent
0 - 5 years	117	14.9
6 - 18 years	90	11.5
19 - 50 years	213	27.1
51 - 75 years	294	37.4
76+	72	9.1

TOTAL NUMBER OF CLIENTS = 786

Title: Incorporating Geriatric and Gerontological Content into the Baccalaureate Nursing Curriculum
Authors: Elizabeth N. Stokes, Ed.D., R.N., C. and Peggy M. McConnell, R.N., M.S.N
Institution: East Tennessee State University School of Nursing

The purpose of this paper is to present the way a baccalaureate nursing faculty incorporated geriatric and gerontological content into the curriculum. This discussion will include strategies for placement of content, relationship of prerequisite courses, and approaches used to incorporate content into courses throughout the nursing major. Illustrative material from a beginning course in adult health nursing will be included.

As the curriculum is changed to include specific content, one of which was aging, care must be taken to maintain the integrity of the curriculum structure. The philosophy of the baccalaureate program supports the professional generalist who provides nursing care to individuals throughout their life spans in structured and unstructured health care settings. The stated desire to prepare the student for present and future nursing practice to meet the challenges of society reinforces the inclusion of more specific aging content. Terminal objectives for the baccalaureate student specifically identify "planning and providing care to individuals/families experiencing developmental and situational hazardous events throughout the life span" as a desired outcome.

The organizing focus of the baccalaureate curriculum at East Tennessee State University School of Nursing is primarily developmental and uses crisis theory as its major theoretical component. Complementary theories include adaptation, self-care, and systems. Geriatrics and gerontological content fit well within this framework. Modifications in the curriculum to accommodate gerontological content included changing the emphasis or topics in courses and adding specific content in selected courses. These changes were fostered by the formulation of course objectives and content outlines that delineated aging content.

In order to strengthen the developmental component, a developmental psychology course was required as a part of the nine hours of social and

behavioral sciences in the general education lower division core. Hours in the natural sciences include four hours of human physiology. In addition, students are required to take a general nutrition course prior to beginning the upper division nursing courses. Lower division nursing courses introduce students to some basic normal life span changes and specific nursing interventions for clients experiencing these developmental hazardous events (i.e., changes in sensory abilities).

Large block nursing courses were broken down into more manageable content/clinical blocks based on our identified theoretical model. At this time the curriculum committee came to the decision point about whether the geriatric and gerontology content should be incorporated into the curriculum or presented in a separate course. Based on the model we had selected and the fact that students care for elderly in several courses throughout the nursing education, incorporation of content was the mode selected. Prototypes representative of identified essential competency areas were chosen as a method of presentation of content. Course content outlines and course objectives were developed to ensure inclusion of essential content areas. Developing course outlines for the entire curriculum assisted the faculty in content placement, continuity, and sequencing. To illustrate, an abbreviated course objective and a portion of a course outline from the course, Care of Adults with Post Crisis Chronic Problems, is given below:

describe how clients with various developmental or situational crises resulting in loss of sensory-motor function and loss of regulation and protective mechanisms adapt to a chronic state requiring major life-style changes.

III. Problems Associated with Loss of Sensory-Motor Function and Mobility
A. Biopsychosocial Aspects and Impact
B. Prototypes
1. Cerebral Vascular Accidents
2. Parkinsonism
3. Alzheimer's Disease

Now we narrow this discussion to the inclusion of gerontological content in a beginning adult health nursing course. The course focuses on the care of adults with commonly occurring health problems. Concurrently students are enrolled in a clinical

practicum course.

Content related to the nursing care of the elderly is interwoven into the course in several ways. These strategies include topics devoted entirely to aging, discussion of aging in relation to a general functional pattern or a specific problem in a functional area, and the use of prototypes exemplifying problems of the elderly client. The course content outlines, the course objectives, and the unit objectives provide guidelines for student learning.

Throughout the study in this course, the course and unit objectives are used as guidelines for reading assignments, classroom activities, and testing. A course objective is presented to illustrate:

> The student compares the developmental and situational aspects of life span changes for young, middle and older adults.

Examples of unit objectives are given below:

> explains mental, physical and psychological elements influencing learning in the elderly. [teaching-learning]
>
> describes aging changes which predispose elderly clients to musculoskeletal problems and injuries. [loss of mobility]

The concurrent clinical practicum provides opportunities for application of classroom learning with assigned clients. All the clinical sites selected have clients in the appropriate age range. Instructors endeavor to provide students with opportunities to care for elderly clients. In addition, instructors use clinical conferences to reinforce content and concepts related to the care of the elderly. When completing a nursing process study, students delineate characteristics of assigned clients which demonstrate their status in relation to developmental stage and accomplishment of the tools and tasks of that stage.

To evaluate this mode of incorporating aging content in this course, the instructor chose to use several tools and approaches. Knowledge relative to aging would be assessed by specific test questions and Palmore's Facts on Aging quiz. A survey of assigned client ages would provide data about the care of elderly clients. A review of developmental data from a sample of nursing process studies would illustrate application of knowledge to clinical situations.

Data from a class of 15 students who began this new curriculum in January 1989 is presented. The Facts on Aging Quiz (Palmore) was given at the beginning and end of the course. Means were 63% and 80%, respectively. Test questions specific to the care of the elderly were formulated. Although each test given in the semester contained questions related to aging content, we are focusing on the 24 questions which were on the final comprehensive exam. Questions ranged from recall to application. The mean for these 24 questions was 21.12 or 88% correct for 15 students.

A survey of ages of assigned clients was taken. Of the 133 clients for whom 13 students cared during the semester, 81.2% were 55 years of age or older. The percentage of assigned clients over 65 years of age was 54%. As a part of the clinical practicum, students completed two in-depth nursing process studies. The assessment data included material on the developmental stage of the assigned client. Students indicated the developmental phase of the client, the tools or tasks for this era, and the achievement of the client in this area. The instructor reviewed student work to ascertain application of developmental concepts, especially in relation to the elderly.

The implementation of a new curriculum necessitates ongoing evaluation. The plan formulated for this beginning adult health nursing course will be continued. An analysis of the unit objectives in relation to competencies in gerontological nursing identified in the curriculum revision process will be undertaken. Two strategies for strengthening student clinical learning in the care of the elderly are being considered. Faculty are exploring additional opportunities for students to be involved with the well elderly. To assist students in applying content, materials for use in clinical conferences may be developed. Suggested materials include objectives to delineate specific learning or discussion guidelines.

Faculty are also preparing to evaluate the total curriculum One of the specific areas for evaluation is the care of the elderly. Although plans are incomplete, use of the evaluation strategies cited will be continued and expanded. Faculty are considering the use of attitudinal surveys and knowledge tests at appropriate intervals.

FACULTY RETIREE DEVELOPMENT AS A RESOURCE FOR UNIVERSITY/COMMUNITY COLLABORATION

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This paper describes the development of a modified joint appointment between a nursing school and a nursing home for a "retired" faculty member. A faculty member of the Northeast Louisiana University School of Nursing was eligible to retire after twenty-five years of service. One year prior to retirement, a local nursing home administrator asked this individual to do some part-time consultation in the area of staff development. The faculty member's mother is a resident in this home; therefore, she has been a frequent visitor. Her professional expertise often was sought by personnel.

In a discussion between the nursing school director and the faculty member, an idea was born to develop a modified joint appointment between the nursing school and the extended care facility. The idea was approved by the nursing home administrator. Support for this endeavor was abundant. It seemed to be critical that this faculty member be additionally prepared. Although her background was very strong in the area of community health nursing, a need existed to increase her gerontological knowledge. To achieve this goal, the faculty member and the nursing school director enrolled in a certificate gerontology program on campus and completed eighteen semester hours of interdisciplinary coursework in gerontology. The process of planning and preparation occurred over a time span of one year.

One week after her official retirement, the faculty member was rehired by the nursing school on a sixty percent basis. The nursing home contracted for forty percent of her time.

A contractual agreement was arranged that clearly delineated the rights and responsibilities of the school of nursing and the nursing home in relation to the professor/consultant. The contract included such specific details as office space, time schedule, and job duties. For example, the individual team teaches and supervises nursing students in a clinical laboratory but is excluded from student advising and committee assignments. The top administrative official in each organization signed this contract, which is renewed on an annual basis. It was important not to exceed the amount of money that could be paid to the retiree from the state system. The hourly consultation fee was negotiated between the retiree and the nursing home. Financially, this dual position has been rewarding to the individual who also is drawing full retirement pay from the state. All money is given directly to the individual.

The project, which is in its first year of implementation, has provided an opportunity for a retiree to share knowledge, skills, and expertise. The nursing school gained her continued employment for a cost effective price. Nursing students see this older professional as a role model.

The nursing home expanded its services to both employees and families. For example, staff development inservice programs have been offered on such topics as body mechanics and infectious diseases. A current focus is on employee wellness through a computerized health risk appraisal program. Families of the nursing home residents have become more involved in governance issues and support groups. More visibility is being sought through grants and presentations.

Nursing Home Programs

1. Employees' Health-Computerized Health Risk Reduction Program The nursing home has responsibility for monitoring the health and care of its residents. These responsibilities include physical care, infection control, safety, and promotion of optimum functioning and quality of life. Since employees are a critical resource in meeting these responsibilities, a proposal was made to incorporate a Computerized Health Risk Reduction Program in the employees' health plan. Observation and interaction with the employees showed many lifestyle choices in the areas of diet, exercise and stress management that were manifested as obesity, chronic malaise, and absenteeism.

The purpose of the health program is to improve the overall health status of the employees by identifying individual health risks and assisting them in changing their lifestyles through education and supportive interaction in individual and group settings. The tool used to identify risks was the Health Risk Appraisal developed by the Center for Disease Control (CDC). This tool has a scientific epidemiologic basis and can serve to gauge risks of a defined population for a number of preventable health problems. Health Risk Appraisal provides a permanent document with personalized information that can be used for group education and/or individual counseling. All employees elected to participate in the project and signed a consent form. After the project orientation, health questionnaires were completed and the data were entered into a computer for computation. A two-page printout of each participant's data outcome was reviewed.

The major areas of concern were diet, stress, and lack of preventive health measures. The employees were then involved in planned group educational offerings, such as dietary modification and stress management. Educational pamphlets and brochures about common health problems were made available. Interpretation, counseling, and referral to community agencies were the responsibility of the Inservice Education Consultant in charge of the project. Interpretation and counseling were crucial to the success of the project. Individual contracting with the employee to change behavior and improve at least one area of health, such as weight reduction, initiation of regular exercise, or cessation of smoking, was offered. The Inservice Education Consultant continues to extend her support with emphasis on positive reinforcement to both individuals and small groups. The Health Risk Appraisal will be administered to each employee in one year and compared with the initial wellness score. At this time, all new employees are being given an initial Health Risk Appraisal.

2. Family Caregivers Seminar - A Caregivers' Seminar "Together We Care and Share," sponsored by Northeast Louisiana University (NLU) School of Nursing and St. Joseph's Home, was held in November, 1988 during AARP's National Family Care-givers' Week.

The programs offered information on physical care skills, spiritual support, stress management and community resources. The senior nursing students at NLU School of Nursing prepared three video tapes that would assist family caregivers in their home situations. The tapes demonstrated a simple bedbath, protective body mechanics, and recreational ideas with a craft demonstration. The tapes are available for home video utilization to members of the community. The seminar concluded with a discussion of the needs of caregivers and homebound persons. The participants completed a program evaluation. They rated the program very good to excellent. A unanimous request was made for another seminar. One is planned for October, 1989.

3. Grant Proposals - Two grant proposals were submitted by the Inservice Education Consultant in January 1989. Recently the Home has received reasonable assurance that these grants will be funded. One grant proposes to develop a multidisciplinary care management model. The second grant proposes a Wellness Information Center to further assist the Home's health care workers in reducing health hazards through utilization of media aids, various health information materials, and independent study modules. This proposal is an outgrowth of the Health Risk Reduction Program at the Home.

4. Inservice Education Programs - A major responsibility of theInservice Education Consultant is to formulate a mechanism to assure that all employees receive annual mandatory education in six important topics. These include patient rights, ethics, confidentiality, infection control, isolation and fire safety. Learning modules are being developed for each of these topics. The modules contain teacher goals, learner objectives, content, demonstration, audio visual material, teacher constructed handouts, discussion questions, and a pre- and post-test. An evaluation rating tool for each program presented has been utilized to determine effectiveness.

5. Infection Control Program - An infection control committee has been organized which includes a retired physician, and an infection control manual for the Home has been developed. The policies contained in the manual are in keeping with CDC standards. Included in the manual is a section on blood-borne disease and was developed to justify compliance with the OSHA (Occupational Safety and Health Administration) hazard standards. HIV/HBV education is routinely provided during the orientation process to all full time and part time employees, including students and trainees. There is written documentation on appropriate education about blood-borne diseases during both orientation and annual continuing education. A monitoring mechanism is in place to evaluate the effectiveness of blood-borne diseases, and a corrective action plan is included that requires re-education for non-compliance. In addition, a central index for all

chemicals used at the Home has been organized to meet OSHA standards.

6. Family Government Council - In January 1989, a Family Government Council was organized. The purpose of the Council is to attend to grievances that family members have regarding policies and resident care problems. These concerns are discussed, and reasonable recommendations are given to the Homes administrator for consideration. The Council has a three member governing board. The Inservice Education Consultant serves as a liaison between the Council and administration.

Because this program is a new endeavor, progression towards goals have been slow. For example, some progress has been made in relocating smoking areas for residents. The Council also sponsors activities to improve services. These activities include a Mother's Day tea and Friday night at the movies for residents and family members. Following the movies, brief reminiscing sessions are conducted. Classic movies, as chosen by the residents, are used to encourage participation. It is anticipated that the Family Government Council will co-sponsor the Caregivers' Seminar in the Fall of 1989.

School of Nursing Activities

The faculty member has continued many of her same activities. She teaches the community health nursing content through classroom and laboratory applications. This includes supervising and evaluating students in a community health department. Since the curriculum materials are team taught, some of her 60 percent time includes course meetings to coordinate information.

Evaluation

Evaluation has been based on feedback from employees, students, residents, family members and administrators. A simple rating tool has been developed to measure the effectiveness of the inservice programs. The ratings have been positive. In June 1989, a yearly site visit was made by a team from the Louisiana Department of Health Standards for Licensing Nursing Homes. The team made no recommendations for the Home's educational program. Both student ratings and annual performance review from the School of Nursing have indicated satisfaction.

As more higher education systems offer early retirement options, "retired" professors may serve as a resource for university and community collaboration. The faculty retiree can be an essential link in the town-gown relationship. Such a utilization of elders is a model available to other disciplines but has much relevance for the health professions.

IV.

FACULTY DEVELOPMENT MODELS: PART 2

Objectives:

Upon completion of this presentation participants should be able to:

1. Discuss the results of a faculty development program in gerontology utilizing summer internships.
2. List the critical elements of developing a town/gown partnership to form a community nursing service.
3. Identify the steps required to draw appropriate conclusions from print media utilized as an instructional method for geriatric/gerontological education.

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Janet Timms, RN, MSN Clemson University	University/Community Partnerships: Development of a Community Nursing Service
*Frank Nuessel, Ph.D. Arthur Van Stewart, D.M.D., Ph.D. University of Louisville	The Use of Popular Print Media Visuals to Dispel Common Negative Attitudes Toward Older Adults

*Denotes Presenter

TITLE: Fostering Interdisciplinary Collegiality in Gerontology through Summer Faculty Internships:
Author(s): T.E. DiMatteo, Ed.D., CRC
W.A. Scoones, Ph.D.
Institution: Ithaca College

Introduction/Overview

The purpose of this case study is to describe the efforts of a faculty development program in gerontology initiated at Ithaca College (IC), a private, nondenominational college in the Finger Lakes region of central New York State. Founded in 1892 as a Conservatory of Music, Ithaca College has an enrollment of slightly over 6,000 students, and is one of the largest private, residential colleges in New York State.

The number of faculty who are academically prepared to teach gerontology is an important factor in the determination of manpower needs. There is a dearth of studies of faculty preparation in gerontology, but the existing research indicate a very limited number available. Bolton (1987-88) notes that a surprisingly high percentage of the professoriate who are teaching gerontology have little or no formal preparation in the discipline. Also, a report prepared by the National Institute on Aging (NIA) (1987) stated that shortages of academicians with adequate training in gerontology are a serious constraint on the development of further activities in training programs. Presently, the number of prepared teaching faculty and researchers ranges from only 5 to 25 percent (depending on the field) of the total number projected to be needed for the development of such activities.

Historically, at IC a substantial portion of the faculties in the professional schools comprised professional practitioners who had become teachers. That pattern has consciously been changed in more recent years; now the primary emphasis in recruiting is on possession of the appropriate terminal degree and teaching experience. Today IC's administration hires relatively young Ph.D.'s in a very competitive job market that includes prospective for-profit employers as well as other colleges and universities. These individuals bring excellent academic credentials and theoretical knowledge of their disciplines, and are or have the potential to be fine teachers and scholars. Few, however, come with any sustained working experience in their field outside of academe. The "real world" of work, for which they prepare and advise many of their students, is not part of their own experience. Moreover, given the emphasis in tenure-track positions on scholarly research and publication as concomitants to quality teaching, many younger faculty in professional disciplines must wait several years - sometimes until a first sabbatic - before they have an opportunity to acquire any substantial practical exposure to their field. Clearly, it is incumbant upon the College to continue to recruit these well-qualified individuals to the professoriate; however, the administration was concerned about addressing their development as rounded professionals who have had firsthand exposure to their disciplines outside of teaching. It was with this backdrop that the development staff approached a funding source and in 1986 the College was the recipient of an anonymously awarded grant in the amount of $100,000 for the teaching and study of gerontology.

One of the stated purposes of the grant was to broaden the base of faculty interest and understanding of gerontology. With only one faculty member possessing a solid background in gerontology and perhaps two others on staff with a nodding acquaintance of the field, we hoped to use faculty internships as a means of both quick and total immersion to gerontology. However, the process had to have legitimacy and had to have faculty ownership or it would lack the credibility so important to a new venture. A peer review process was used to select the summer awardees while a modest publicity campaign was established to create interest in the summer internship program. A letter explaining the objectives, goals and ground rules for the internships was sent by the Dean and program coordinator to all members of the faculty. In addition to the letter of explanation, a proposal form was included along with the deadline dates and an invitation to an explanatory session held by members of the Gerontology Task Force - a joint faculty-administrative group established to give the program thrust and direction. Over a dozen faculty members responded affirmatively to the call to the explanatory/mentoring type session held in November. Members of the Task Force explained the function and purpose of the grant and how the internships fit into the overall mosaic of a campus-wide gerontology thrust. Faculty members were told that their proposals would be subject to a peer review with the Dean and Provost also signing off on the proposal. Awards were similar to other Ithaca College internal summer grants - a $3,000 stipend, some travel and equipment funds, and a follow-up grant of up to $1,000 if an awardee wished to work on a curriculum project to infuse gerontology into a course(s). Over three summers nine proposals involving eleven faculty members have been funded, although one was aborted when some of the planning details could not be concluded in time for the project to start.

The summer internships were not construed as research projects. Rather, they have been viewed instrumentally as a mechanism to whet faculty interest in an emerging field. The next section of the paper is a summary of the internships which have been funded over the past three years.

1) Proposed by an anthropologist, the first internship was with the Center for Environmental and Social Studies on Aging (CESSA) in London, England. This professor studied the attempt on the part of the British to deinstitutionalize geropsychiatric patients into what we would term half-way houses. This internship provided the faculty member with direct access to British elderly individuals, their caregivers, and the policy-makers.

2) Submitted by a member of the Physical Therapy faculty and an Assistant Professor of Cinema and Photography, this was a collaborative venture intended to familiarize both faculty members with the spectrum of services, attitudes and people that make up the "elderly" and their institutions. The two applicants interviewed and observed residents, staff and administrators of several nursing homes. Their end product was the production of a 1/2 hour videotape which portrays the spectrum of services and institutions.

3) Submitted by a member of the Recreation & Leisure Studies Department, the internship grant allowed the individual to spend

four weeks with the Department on Aging and Disability in Chicago. During this time the applicant worked with the Director of Program Services. The applicant increased her awareness of the varied interests and needs of the heterogeneous, multi-cultural, older population served by the Chicago Agency.

4) Submitted by a member of the Cinema and Photography Department, this individual explored photographically the dynamics of the special population of aging gay men and lesbians living in New York City. The photographs consisted both of environmental portraits and individual ongoing photo essays supplemented by oral histories. The stereotypes perpetuated by our youth-oriented culture portray the older person as inactive, useless, unproductive, and asexual. Older gay men and lesbians must bear the additional burdens of being viewed as sick, deviant, and perverse.

5) Submitted by an Associate Professor in the Health and Physical Education Department, the faculty member worked with a local nutrition program (congregate meals for the elderly). The purpose of the internship was to offer the participants in the program an opportunity to gain insights into a number of health-related concerns associated with aging. This internship offered an opportunity for retirees to gain valuable information to constructively manage these health concerns. Based upon interest ratings from the participants, eight specific topics were covered. Each weekday during an eight week period, a different meal site was selected. Each session provided an opportunity for dialogue on the selected topic.

6) Submitted by an Associate Professor in the Speech Pathology and Audiology Department, this internship involved two specific projects at the County Office for the Aging (COFA). First, the awardee assisted in the revision and design of a new brochure describing the various services and functions of the agency. This project had been identified by the Agency Director as one which was both needed and desired. The individual gained first-hand exposure and information relative to COFA. Secondly, applicant worked on development of a single T.V. program and possible model for a series for senior citizens. The faculty member's experience in video served to facilitate his role of media liaison between COFA and the local Cable Channel.

7) Submitted by a faculty member in Exercise and Sports Science, this grant allowed the recipient to spend six weeks at the local community hospital's "Silver Service Program." The purpose of the program is to offer the elderly easier access to health care while also offering these individuals programs designed to assist them with increased quality of life and independence. The faculty member became involved in formulating and developing focus-groups, both to determine the initial impressions of the program as well as to assess additional needs of the elderly for future program expansion.

8) Submitted by a nutritionist, this project enabled the individual to work with the County Nutrition program. The program is a non-profit corporation which provides meals to elderly who are (a) low income, (b) minority, and (c) socially isolated.

Outcomes/Implications

No formal assessment procedure has been established. Subjectively, however, it is apparent that the gerontology curriculum is being strengthened by the "real world" base that each faculty person has added to his/her discipline. In terms of tangible results, the anthropologist teaches a course in aging and cultures. Having spent a full year in London, he has incorporated a wealth of information to add to the course. The Speech Pathologist spent eight weeks at the County Office on Aging, and now has a more thorough understanding of networking and agency services which are available for older clients. He has expanded his course in Communication Disorders and the Elderly from one to three credits, with added focus in the course on agencies serving the elderly. One of the Assistant Professors from Cinema Studies and Photography will be developing a film series related to aging. It is evident that the campus is experiencing an awakening of faculty interest in aging. Outcomes of the two internships funded during the summer of 1989 are yet to be determined.

We do not expect to fund internships beyond next summer unless we secure external funding. More likely, we will treat gerontology like we treat all other academic areas and expect our faculty to compete for research grants, either internal or external to the College. If we have built the base carefully, and properly nutured our faculty, the next steps seem inevitable; faculty begin to write and profess in gerontology. Then they will want to extend their commitment and understanding to gerontology by further reading and scholarship. Once they reach this stage they will need external funding and will then be treated like their faculty peers in other academic disciplines.

Over the next three to five years we expect the faculty interns to accomplish several curriculum related tasks. We know, from discussions and curriculum meetings, that new units of instruction in gerontology are being proposed and accepted in wildly different disciplines. We fully expect this to continue. We also expect more new courses in gerontology will be created and taught.

Last, we expect that the College and its faculty will play a much larger role in the county agencies and organizations which are involved in providing services to the aging. Once a faculty member has spent most of the summer in an agency, he or she begins to appreciate the problems/issues inherent in that agency. We expect that our interns will take the lead in making our College the information dispensing/clearinghouse that we envision it becoming. While the proof is in the incubation stage we have every expectation to believe that the faculty summer interns have made a commitment to gerontology and to older people for the "long haul."

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A UNIVERSITY/COMMUNITY PARTNERSHIP: DEVELOPMENT OF A COMMUNITY NURSING SERVICE

BY

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A UNIVERSITY/COMMUNITY PARTNERSHIP: DEVELOPMENT OF A COMMUNITY NURSING SERVICE

Clemson University, South Carolina's land grant university, offering graduate and undergraduate degrees to students in 9 colleges, is located in northwestern South Carolina. The main campus was established in 1899, when public pressure resulted in development of these land grant institutions which were established to provide training for local residents, to harness intellectual resources, and to provide technical assistance and public services relative to the social and economic problems of the states (Bass, 1987). Clemson University, recognizing this mission of community service as a land grant university, developed a community nursing service by entering into a partnership with a retirement community located near the university. The common goal was to improve the quality of life of the residents of the community. At the same time, this joint venture also enhanced scholarship by providing practice and research opportunities for nursing faculty and students.

This paper provides a case study description of the development of the Community Nursing Service. Critical elements of program development included in the discussion are (1) establishing community support, (2) developing guidelines for care, (3) conducting community needs assessment and analysis, (4) Certificate of need and contractural requirements, (5) determination of scope of

services, (6) marketing strategies, and (7) faculty and student development.

PROGRAM DEVELOPMENT

For this project the financial base was established for start-up costs when residents of the retirement community made a commitment, financially and philosophically, to fund the service for the initial year of operation. The next step for program planners was to gain the support of the wider community to have the University provide health services for the elderly in the community. The Dean of the College of Nursing, the Department Head of Professional Development and Services, and the Director of the proposed program met with individuals in the community who were identified as having interests in providing health services to older residents. These individuals included local physicians, health department officials, owners and managers of private home health agencies, and other community leaders. The plan for the program was explained and issues and concerns were addressed. The meetings also provided opportunities for wider community to offer suggestions for program planning.

After having received verbal and written support for the service, nursing faculty responsible for program planning began meeting regularly with an advisory group from the retirement community to receive input for planning the health services and health education programs for the nursing service. Drawing from a widely held theory from

adult education literature, program planning was based on the assumption that individuals will tend to feel committed to decisions or activities to the extent that they participate in the planning process (Knowles, 1970). Meetings with the community advisory group proved to be an important element in the on-going operation of the nursing service.

Needs assessment, an important first step in program planning, "is a process that defines desired goals, places them in priority order, and selects those of highest priority for action" (Smith, Smith, and Ross, 1982, p. 53). Two major purposes of needs assessment are to document needs and interests of the target group and to market one's program (Farley & Fay, 1988, Kennedy, 1983).

To develop the needs assessment questionnaire, program developers reveiwed assessment tools in nursing literature, considered data from a previous needs assessment in the community (Euster, 1985), consulted with the advisory committee comprised of residents of the retirement community, and consulted with other nursing faculty at the University. Nursing faculty knowledge and skills were also utilized in the actual work of data collection.

Several weeks prior to data collection, questionnaires were distributed to residents for completion. Then personal interviews were conducted with residents to discuss the questionnaires as residents shared their perceptions of their health status and needs, and their priorities for

program planning. Factual data as well as subjective attitudes and opinions were elicited. The needs assessment tool provided information related to health status, support systems, medications, self-maintenance, activities of daily living abilities, and preferences for health education and services. Once the data were collected and analyzed, conclusions were reported to the residents for recommendations for program planning.

In addition to providing data for determination of services for the nursing program, the data compiled from the needs assessment survey provided documentation to support an application for Certificate-of-Need. South Carolina is one of the states to require Certificate-of-Need approval by the Department of Health and Environmental Control to operate a home health agency. Certificate-of-Need approval is one method of dealing with health care inflation (Barger, 1982). Application for licensure follows Certificate-of-Need approval. To allow nursing faculty to provide home health services and file for third party reimbursement while gathering data to support the Certificate-of-Need application, contractural arrangements were made with the local Health Department. Having a contractural agreement in place with the Health Department also allowed for back-up nursing services and provided other health services such as physical therapy, home health aide services, and consultations with registered dieticians.

SCOPE OF SERVICES

The client profile emerging from the needs assessment data provided guidance for planning the scope of services for the nursing program. In response to residents' wishes, an on-site nursing clinic and a home health service were established. Nursing services included health assessment, screening for specific health problems, health promotion activities, health education, case management, and skilled nursing by physician referral. A high priority for many residents, identified in the needs assessment interviews, was to delay or avoid institutionalization, and remain in their homes as long as possible. Considering this priority, goals of the program included identifying persons at risk for illness, assisting individuals in the management of acute and chronic illness, and promoting high level wellness.

MARKETING STRATEGIES

"Nurses may believe that the value of their services speaks for itself and requires no marketing; however the changing competitive nature of the health care environment may find nursing coming up short" (Barger, 1986). Recognizing the importance of increasing the public awareness of the community nursing service, and maximizing utilization of the program, nursing faculty employed several marketing strategies. An open house and reception was held for community residents, brochures were distributed to individuals and community groups, discussion meeting were

held with groups of residents in various locations at the retirement complex, notices were posted in the local newsletter distributed throughout the retirement complex, personal written communication was delivered to each resident on several occasions, and the nursing service was discussed individually with health care providers and other community leaders locally and in towns nearby.

FACULTY AND STUDENT DEVELOPMENT

The Community Nursing Service, directed and staffed by nursing faculty provides an excellent setting for faculty and students to maintain and improve nursing skills, meet educational objectives, identify problems, and conduct nursing research. It is suggested in nursing literature that nurses may lose their specialized competence when they 'teach but do not touch' (Nichols, 1985). One way to bridge the gap between nursing education and nursing practice is to practice in clinical sites administered and staffed by nurses (Barger, 1986, Nichols, 1985). In this Community Nursing Service, faculty and students are provided challenging opportunities to integrate theory, practice, and research, while providing an important service to the community. Examples of health education projects conducted by faculty and students in the retirement community have included CPR classes, management of such health concerns as heart disease, increased cholesterol levels, hypertension, arthritis, diabetes, bowel and bladder problems, and weight

control. Clients have also received counseling regarding medication side effects and exercise for older adults.

The nursing service provides a controlled practice environment for student clinical experiences near the University, decreasing travel time for students and increasing time for client care. Faculty have become increasingly visible to residents of the community, demonstrating innovative leadership, providing high quality nursing care in the community, and functioning as positive role models for nursing students.

CONCLUSION

The response to the program by health profesionals in the community, residents receiving care in the community, students, and faculty has been positive. The belief has been expressed verbally and has been demonstrated that nurses can positively affect the quality of life for the community by assisting individuals in making appropriate health related decisions. Given the prediction that health care professionals entering the workforce today will spend approximately 75% of their professional life taking care of persons over age 65, (Waters, 1989), it is hoped that other facilities managed and staffed by nurses will be developed to expand the range of community-based health care services, and to advance nursing scholarship, research, and practice opportunities.

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Title: The Use of Popular Print Media Visuals to Dispel Common Negative Attitudes Toward Older Adults

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Institution: University of Louisville

SUMMARY

This presentation provides participants with a list of mythic popular concepts about older adults, a typology of print media depictions of this heterogeneous group, and a specification of the four common mechanisms that misrepresent older people. The ubiquitous nature of these misrepresentations contributes to problems in communication between health care professionals and older adults. Suggestions for the selection of materials will be offered. Copies of exemplary materials will be available for participants. A comprehensive seventeen page bibliography of ancillary materials prepared by Frank Nuessel will also be provided.

Popular culture provides the gerontologist with a veritable plenitude of materials well-suited to purposeful pedagogical objectives. The print media (newspapers, magazines, cartoons, birthday cards, advertisements, literary materials, scripts, advertisements, and other materials) remain a rich source of supply.

Renowned gerontologist Robert N. Butler (1975:6-10) has identified several common myths concerning older adults: (1) chronological aging; (2) unproductivity; (3) disengagement; (4) inflexibility; and (5) senility. All of these widely held and erroneous beliefs about older adults distort our perception of older adults and reinforce inaccurate and generally negative impressions of older people. Many of these misconceptions derive directly from scripted materials.

Judicious scrutiny of the print media shows a tripartite typology of noxious misrepresentation of older adults. The printed references to members of this group often include the following: (1) physical manifestations of aging (hair color, hair loss, skin texture, posture); (2) mental ability (memory loss, declining reasoning powers); and (3) behavior and demeanor (irritability, obsolescence).

Four standard mechanisms exist to exaggerate and contort the heterogeneous older adult population (Nuessel 1982:276). First, distortion results in the depiction of all older people as possessing a common core of generally negative physical, behavioral and mental traits (toothlessness, grumpiness, senility). Next, degradation is another frequent device employed to characterize all members of the group we label "old" by portraying individuals as socially inept and intellectually inferior. Third, subordination is a vehicle for relegating older adults to a subservient position by

minimizing their contributions to a capitalistic production-oriented consumer society. Finally, exclusion may be the most potent instrument for trivializing older adults. Absence of an entire cohort of the population is undesirable because their omission signifies that older people lack any value in our society.

As the title of this paper suggests, the introduction of popular print media materials into lectures or formal presentations can encapsulate many of the incorrect orthodoxies about older adults. Subsequent incorporation of appropriately selected materials can aid in highlighting error-laden beliefs and substituting factual and accurate concepts and information. The materials chosen may supplement a single lecture for public presentation before a lay audience or the items may be integrated appropriately into a particular course in a given curriculum in the social, biological sciences or the humanities.

The use of popular print media materials to dispel common negative attitudes toward older adults involves the following strategy:

1. Select an appropriate document (advertisement, greeting card, cartoon, advice column, etc.) familiar to the target audience. Each item should focus on a particular theme (noted in the preceding paragraphs).
2. Label the item carefully (source, date, page, cost) for future identification, attribution and possible reimbursement.
3. Determine the desired presentation format (slide, overhead, photocopy).
4. File materials according to an easily retrievable system.

The authors have assembled materials in a variety of presentation formats (slides, photocopies, overheads). Preparation of the materials is a relatively simple matter. Though intended for second-language pedagogy, Wright's (1976) book on visuals provides many useful suggestions for preparing materials for educational settings which the gerontologist may find illuminating. Part two (Wright 1976:66-89) deals with the various means of introducing materials into an educational setting (blackboards, overhead projectors, realia, slides and filmstrips). Conspicuous by its absence, yet easily explainable because of its publication date (Wright 1976), is all reference to the computer and the use of sophisticated software programs with enhanced graphics and auditory components such as Apple's Hypercard for self-paced instructional formats. Chapter three (91-108) treats the perception of visual materials (content, shape and composition, solidity and space, color, tone, line, movement, realism and symbolism, and typeface and lettering). The fourth section (110-143) provides important tips on how to prepare visual materials for instructional purposes (design and layout, display and manufacture).

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V.

1. MENTAL HEALTH AND AGING: PSYCHOPHARMACOLOGY IN THE ELDERLY

JAMES M. TURNBULL, M.D., FRCP(C)

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Objectives:

Upon completion of this presentation participants should be able to:

1. Describe the common problems associated with multiple drug use in the elderly.

2. Identify common and not-so-common side effects of psychopharmacological agents in the elderly.

3. Reiterate symptoms in the elderly likely to respond to antipsychotics.

4. Describe the APA guidelines for prescribing:

   - Antipsychotics
   - Antidepressants
   - Hypnotics
   - Anxiolytics

5. Discuss drug use in the elderly under the general headings of:

   - Neotropics
   - Lithium
   - Research
   - Stimulants

2. LONG TERM CARE POLICY ISSUES

HENRY M. WIEMAN, M.D.
MEDICAL DIRECTOR
HIGHLAND LONGTERM CARE FACILITY
FITCHBURG, MA

Objectives:

Upon completion of this presentation participants should be able to:

1. To identify and describe conflicts in the missions of long term care facilities and agencies.

2. To identify and be able to create policies which implement missions discussed.

3. To identify and respond to constraints on policy options in the current regulatory, legal and financial enviroments.

LONG TERM CARE POLICY ISSUES
presented by HENRY M. WIEMAN MD
JULY 25, 1989

Intoduction

This paper was presented at the OVAR Leadership in Geriatric Care Conference. Long term care policy was the subject, but I confined my presentation and this paper to institutional long term care and neglected home and other community care.

Mission, that sense of overall direction which gives an organization motive and coherance is lacking in nursing homes. Several kinds of problems are addressed in nursing homes, but they conflict and confuse eachother. The include medical care, rehabilitation, hospice care, dementia care, residential setting for frail elders and the negativly motivated need to segregate and warehouse the elderly. Taken separately, all but the last are motivating and positive. Taken together they cancel eachother leaving an environment where standards and regulations, by default, focus on safety and scandal prevention. This avoidance based system stifles innovation and morale.

Proposals for improvement center on redefining long term care institutions on the basis of mission rather than on process. Regulations must also be specialized so that meaningful outcome orieanted standards can be forged.

The Biopsychosocial model of Long Term Care Facilities:

As applied to humans, the Biopsychosocial model refers to the seamless whole of the organism whether analyzed at the chemical, cell, tissue, organ, system, person, or social levels. Medical science traditionally focuses on the intra-organism level; chemicals, tissues and organs tend to be the subjects of the physician's attentions. But, as the wholistic movement has emphatasized, that level of analysis will often fail when the psyche and social milieu is ignored. The levels interact and although specialized expertise is neccesary, ignorance of other levels can be lethal.

Long Term Care facilities, as small societies, must likewise be analyzed on multiple levels. The primary level of analysis, the atom, of the Long Term Care Facility is the aide at the bedside of the resident. The nurse, the supervisor, the physician in a strained and non-linear fashion, the administration, owners and finally, the inspecting agencies and the polity that generates and sustains the regulators lie at the most powerful but also most remote level. As failing to acknowledge the import of social realities in medical conditions can be lethal, so failing to take into account the politics of Long Term Care on the political level can be lethal to understanding the function of the aide at the bedside.

The Importance of Mission to Organizations:

Mission is the prime mover of an organization. Even when profit is the driving force, there must be something that makes an organization worthwhile to customers; the reason for existance of the organization. Missions can be general and even utopian, but they when they are inconsistent with real activities, it is at the cost of morale. People will work hard for a mission they can grasp, even when the mission has little intrinsic value. Sports, for example, motivate people to great effort, pain and risk. In the case of Basketball, for example, mission of the activity is to put a ball into a slightly larger hoop more often than somebody else does: an activitiy without intrinsic value. Objectives and goals guide people in their daily work activities; mission gives them a reason to come to work.

The Problem with Long Term Care it doesn't have a Mission!!

It might be objected that Long Term Care Facilities do, in fact, have missions. Nearly every such facility has a mission statement written somewhere, which hardly anybody reads and which states something about caring for the health, social and spiritual needs of elderly people. Unfortunately, as will be discussed shortly, there is considerable conflict between the various tasks that long term care facilities take on. Furthermore, the Long Term Care Facility is coerced to perform certain social control functions by the larger society it finds itself in. These are hidden and largely unmentionable. This leads to a situation where employees are asked to perform a helping, caring role and they wind up performing incarceration and other odious roles which leads to the all too familiar cycle of burnout and turnover.

Another result of the lack of mission is powerlessness. Organizations, or suborganizations, gain power to regulate themselves and freedom from the broad brush bureaucratic rules when they have a demonstrable and compelling mission. For example, the ICU and the Operating Room within the hospital funtion and are designed in ways that aren't tolerated in other institutions or in other places within the hospital. ICU patients have no privacy; they are in visible contact with nursing staff all the time. They usually have no windows in their rooms. These conditions contravene various rules of design and patient rights, but since the mission is life saving and clearly effective, nobody raises the question. In long term care facilities, since the mission is so vague, default regulations which are obsessed with safety and control of deviant behavior.

To appreciate the importance of a mission, compare the morale of a football team or an army in a just war or the staff of an operating room or ICU with the morale of the average long term care facility staff. When people, no matter how humbly educated or poorly paid, know success from failure and know how to make a difference they will work for it.

The aide at the bedside, no matter how burned out, , wants to help. If she didn't she'd be slinging hash. How what she does

affects the welfare of the residents is THE task of staff education, and at least a major component of the task of management. It must ultimately be the task of the regulator and political level as well, since realistically viewed, the regulatory system is part of the management.

What Might be A Mission for Long Term Care?

It's not an easy question. For a mission to work, the organization must be able pursue it single mindedly and without conflict. The soldier in the trenches can tolerate imperfect leadership, but he can't tolerate a traitor in headquarters. If a mission is accepted, activities that conflict with it must be expunged.

Possible missions for long term care include the following:

1. Half Pint Hospital
2. Rehabilitation Center
3. Dementia Care
4. Golden Age Retreat
4. Hospice
5. The Dark Side

Half Pint Hospital means means curative intervention by physicians with nursing help on patients who have little control or responsibility. It's important to note that the locus of power in this system is the physician and secondarily, the nurse. Values which operate in this model are medical cure or improvement. Appropriate standards would be the same as those used for a hospital: Quality Assurance with medical care audits and similar tools would be useful. Number of improved discharges to home or lower levels of care whould be a prime measure of success. Note that the physician's judgment of what is good for the patient is considered to be primary. It's true that consent of the patient is more important than in the paternalist past; nonetheless, the doctor knows best, at least most of the time. There is nothing less home-like than a hospital and in long term care facilities with hospital values, any pretense of offering a pleasant homelike environment is unlikely to be very realistic.

Rehabilitation Center means a no pain no gain approach with patients being coached and motivated to help themselves by aggressive therapists. Patients are expected to help themselves but only with the guidance and forceful encouragement of therapist. The locus of power would be the physical therapist and the interdisciplinary team. Values served are hard work, exercise, and improvement in functional ability in spite of incurable disability. Standards would be frequency of success of therapy plans and discharges to lower levels of care. Note that the nursing model is often in conflict with this model. Furthermore, amenities of a homelike atmosphere is not valued in this model. The Rehab center shouldn't be too comfortable, but rather a place people are motivated to "graduate" from. The social norms of the community of

residents plays a role as well. In a place where everybody is expected to be up, dressed and trying to be as mobile as they can is a much different milieu than, say a hospice where people are allowed the freedom to be as "sick" as they choose.

Dementia Care specializes in maintaining, but rarely improving function of a particular common, incurable, chronic illness. Flexibility of the environment to tolerate and respond creatively to behavior problems and confusion in the main value. The power might be centered in the activities director (a contribution from members of the audience during the presentation) and/or the aides and nurses. Possibly the family members of the residents should be invested with power as well. The residents, by definition, are incapable of self government, but their apparent preferences should certainly be given weight since the prime value is quality of life. Cure or medical improvement is conceeded to be unobtainable. Standards might involve rate of decline, appearance of contentment, activity and comfort of residents. Note that a place where demented people are happy would probably be most uncomfortable for clearheaded but frail elders. Allowing the freedom of the demented to wander and explore is intolerable to people who are physically vulnerable.

Golden Years Retreat means a place where happy residents who, as customers, are always right. Quality of food, decor and recreational activities are most important objectives. Satisfaction of the resident is the only standard. Many long term care facilities claim a Golden Years Retreat type mission but if they really meant it, residents (who would never be called patients) would be free to refuse their medical treatments without a second look as people are allowed to do in the privacy of their homes. They would likewise be free to choose their eating guests, room mates etc.

Hospice means the last harbor where dying people are given succor without invasive medicine. Values are death free of pain and personal control of the immediate environment. Personal comfort and abandonment of rehabilitation or curative intervention is valued. Power is again resident centered, with input from relatives and spiritual professionals. Standards are pain control, availability of spiritual succor, and family satisfaction. There is clear conflict with medical and rehabilitation models.

The Dark Side refers Long Term Care as a Land Fill for humans where the rest of polite society can hide the helpless, unproductive and frightening reminders of our own frailty and mortality. Premium values are financial efficiency and scandal prevention. Although an ugly and frequently denied motivation, this set of values remains as an important determinant of regulation and policy. One of the most insidious effects of this model is the paranoid avoidance of risk. Perhaps because of underlying guilt, any accident is viewed as criminal and requiring policy overhaul. Since there is no other function of the facility than to keep

people hidden and safe, any threat to safety is unconscionable. The effect is to maximize use of restraint and restriction of freedom.

Long Term Care Facilities Function with all these missions but they are not compatible with eachother. Consider the Aide at the bedside: the curative patient has signs and symptoms recorded the rehab patient is cajoled and prodded and helped minamally while the hospice patient is given every consideration to comfort and helped maximally while the golden agers are treated like royalty. Few people are really capable of playing all those conflicting roles at the same time, let alone keeping accurate track of which resident is a resident is a patient etc.

Regulatory Policy:

There is a tragedy of ever dissipating locus of control in long term care facilities. By putting safety first, thereby focusing on prevention of falls, violent acts and other mishaps, the regulators inevitably force the facility to take control away from the residents. Ask people in nursing homes, whether residents, staff or management and you'll find people who don't think they can do anything about their environment. If they are residents it's called depression; if staff, it's called burnout, but it's the same thing. Even regulators are bound by the regulations they enforce and the array of sometimes conflicting agengies impinging on them. This is the result of multiple conflicted and to some degree unacknowledged missions.

The premium placed of scandal prevention, as well as the limited resources available, has the effect of stifling innovation in the long term care industry. With risk avoidance being primary and capital formation being difficult, new concepts are unlikely to see the light of day. It sometimes seems as though whatever is not mandatory in long term care is forbidden.

Even when the political system promotes one of the positive missions, difficulties can arise because of the difficulty in planning for the energy. Resource Utilization Groups in some states promote rehabilitation and medical models. However, facilities which capitalize efforts in that direction my be loosers if the priorities of the political system shifts in the future. Rotating political goals can result in instant obsolescence. The result is managers who are understandably cautious; i.e. innovation aversive.

How it Could Be Better:

The fundamental proposal of this presentation is that long term care be unbundled. The functions which the present long term care system serves are so disparate that useful regulation and management is impossible. High morale organizations are centered on a mission, not the process they perform. It is proposed that the separate missions be given organization of their own and that they be regulated, planned for and funded separately. If the dark side mission is untenable, that specializing the other functions will only make that more apparent.

The importance of maintaining separate regulation cannot be overemphasized. Regulation is probably inevitable, (and even desirable) in long term care. It is naive to view regulation independant of management. Therefore, if separation of function is to be meaningful, it must include regulations and the political system which supports them. Then the debate over what would be good regulations for each of the missions could begin. As long as policy debates have to cover the whole gamut of missions, no cohesion can be expected.

Hospices work fairly well. They can afford motivation because they have missions. Scandal prevention is easier since the range of problems at admission is restricted; people for whom the hospice model is not appropriate are not admitted. Although the high burnout in geriatric care is often attributed to the fact elders don't improve, many highly motivated people can be found for hospice work. The hospice care needs of people who find themselves in long term care and of demented people are more problematic. I propose hospice care in nursing homes with current hospice standards and methods and separately defined and regulated.

I propose Dementia care units with specialized training and techniques and regulation. Architecture and interior design should also be specialized. Literature on this as begun, but usually the issue of design is directed to needs of frail elders in general. Requirements for physician attention after first evaluation could be reduced but increased values of ADL. Activity and exercise programs instituted.

I propose Extended Hospital Care (Medicare) units that can cooperate with acute care units easily allowing smooth transitions and higher levels of physician and nursing intervention than is currently funded in nursing homes. This (but certainly not most of the other missions for long term care) would be an appropriate use of idle acute care hospital space.

I propose Long Term Rehab units for people requiring rehabilitation taking longer than a month and shorter than a year. In this environment all the people, staff and patients are geared to improvement, goals are posted on the wall, and graphs of progress are routine. Values of comfort and environmental pleasantness are only secondary and the transitory nature of the stay is assumed. Functional team process would be mandatory.

Conclusion:

Nursing home care is an industry in search of a mission. Several viable missions exist but conflict with eachother in the current nursing home setting. Instituions defined by, designed for and regulated with a single coherent and integral mission is called for.

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3. PULMONARY ASPECTS OF AGING

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DIVISION OF RESPIRATORY AND ENVIROMENTAL MEDICINE
UNIVERSITY OF LOUISVILLE
LOUISVILLE, KY

Objectives:

Upon completion of this presentation participants should be able to:

1. Review the expected changes in pulmonary function that occur due to the aging process.
2. Review the limitations of pulmonary function testing as it applies to the elderly.
3. Review the influence of age on the expression of pulmonary disease.

4. PLANNING HOME VISITS: WHO, WHEN AND HOW

M. SHANE GAINEY, M.D.
EVELYN L. FITZWATER, RN, MSN
GERIATRICS DIVISION
UNIVERSITY OF CINCINNATI

Objectives:

Upon completion of this presentation participants should be able to:

1. Discuss historical and current perspectives on home visits.
2. Construct a model team for home visits.
3. List two advantages/disadvantages to home visits.
4. List three types of patients that would benefit from home visits.
5. Discuss financial aspects of home visits.

5. AGE RELATED CHANGES: USING SIMULATIONS IN GERIATRIC EDUCATION

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UNIVERSITY OF KENTUCKY

Objectives:

Upon completion of this workshop, through active participation in discussion, simulations, and by reference to the print materials, the participant will be able to:

1. Discuss a rationale and procedural considerations for experiential learning as one approach to assist students develop an understanding of age-related changes and empathy for older persons.

2. Describe visual, auditory, olfactory, and gustatory changes/losses in older adults and the implications (resultant effects) on behavior.

3. Identify several specific empathic activities which stimulate sensory deprivation in the older adult.

4. Outline the major steps of a selected debriefing process that should be integral to conducting any simulation experience.

5. Identify existing resources and available materials that can enhance insight and understanding of age related changes and that can be adapted for classroom use by instructors as they teach persons who work -- or will be working -- with older adults.

6. ENHANCING QUALITY OF LIFE THROUGH HEALTH PROMOTION EDUCATION AND CAREGIVER SUPPORT

PHILIP OLSON, PH.D.
TOBY TURNER, MN, RN, C
Center on Rural Elderly
UNIVERSITY OF MISSOURI-KANSAS CITY

Objectives:

Upon completion of this presentation participants should be able to:

1. Identify key characteristics in health promotion education programs.

2. Discuss the effects of health promotion education on the self care abilities of rural elders.

3. Distinguish education/training, respite and support groups as three intervention strategies for families caring for frail elders.

4. Identify some of the models available to assist practitioners in developing and implementing education/training, respite and support groups.

Enhancing Quality of Life Through Health Promotion Education and Caregiver Support

Possessing knowledge of health and skills of self care enhances the quality of life of older persons. They are empowered to sense control of such take charge of personal decisions and accept responsibility for lifestyle decisions which impact their lives.

The 60's and 70's brought the technology which would increase the number of persons who would survive to old age from both ends of the continuum. Because of that technology, infants survive, often with significant cognitive and functional impairments and elders survive longer but also with chronic disease and disability.

The 80's has brought a realization that longevity alone, without quality of life, is not a reasonable goal for anyone. There has been movement toward creating a balance for the almost unbridled technology of the previous decades. No issues in this nation's health policy agenda deserve more attention than those associated with the implications of growing old and quality of life.

There are some 30 million elders residing in this country. According to 1980 census data, 25.4 percent of all persons over the age of 65 live in rural communities of less than 2,500, 8.3 percent live outside urbanized areas in communities of 2,500 to 10,000, and 15.1 percent live outside urbanized areas in communities of more than 10,000. Clearly there is a need to have mechanisms in place which will enhance knowledge and teach self care skills to those elders who live in rural areas and small towns which tend to have minimal resources such as hospitals, universities, private health agencies and even public health agencies than urban areas. Local governments, health service providers and lay community leaders frequently take the responsibility to develop and support strong health promotion and wellness and caregiver support programs.

The Center on Rural Elderly was established in 1987 through a grant from the W.K. Kellogg Foundation and support from the University of Missouri-Kansas City to serve as a resource to those persons in rural areas and small towns who wish to provide community-based health promotion education programs for elders. The Center provides opportunities for those persons working in rural areas to learn about available programming options which educate elders and their families and to network with others involved in community-based programming. Specific areas of interest to the Center are 1) positive preventive health practices 2) support for family caregivers of physically, cognitively, and emotionally frail older adults, and 3) promotion of positive intergenerational relations.

The following are examples of resource materials available from the Center on Rural Elderly:

THREE INTERVENTION STRATEGIES FOR USE WITH FAMILY CAREGIVERS OF FRAIL ELDERS

EDUCATIONAL WORKSHOPS

Educational workshops are designed to provide caregivers a structured forum in which to learn skills and information about the tasks they face in providing care to frail elders. Classes, or sessions, can include lectures by professionals and possibly group interaction. Manuals have been developed by the professionals who conduct these workshops to assist others in presenting similar opportunities for caregivers. The manuals have (1) information on how to deliver the program (i.e., how to obtain publicity, how to invite guest speakers, how to form a community task force) and (2) curriculum information to teach participants.

Examples are VOLUNTEER INFORMATION PROVIDER PROGRAM by Share Bane and Burton Halpert, University of Missouri-Kansas City; HELPING FAMILIES HELP by Rhonda Montgomery and Beverly Crump, University of Washington; FOR THOSE WHO CARE by Cynthia Higbea, Lee Memorial Hospital, Ft. Meyers, Florida.

RESPITE

Respite is the short term substitute care of frail elders in order to provide relief to caregivers. The primary beneficiaries of respite are those caregivers who receive "time off" from the job of caregiving. Respite can be provided in the home or in a community facility, such as a nursing home or adult day care. Materials have been developed which provide information on "how to" develop respite programs to caregivers. These manuals are targeted at the practitioner in the community and include information such as how to recruit volunteers, how to publicize the respite program, how to recruit families who will use the respite, and how to supervise the volunteers.

Examples are RESPITE, HELPING CAREGIVERS KEEP ELDERLY RELATIVES AT HOME by Peggy Eastman and Annette Kane, National Council on Catholic Women, Washington, D.C.; IN HOME RESPITE CARE by Edna Ballard and Lisa Gwyther, Duke University.

SUPPORT GROUPS

Support groups provide an opportunity for caregivers to relate to other people facing the same emotional, social, physical, and psychological issues of caregiving. Groups provide support and, in many cases, also provide education to members. Materials have been developed by professionals who conduct support groups. These materials teach other professionals how to conduct and facilitate support groups.

Examples are P.O.P.S., POLISHING OUR PEOPLE SKILLS by Good Samaritan Hospital, Portland, Oregon; STARTING A SELF-HELP GROUP FOR CAREGIVERS OF THE ELDERLY by Louise Fradkin, Mirca Liberti, Jacob Stone; Children of Aging Parents, Levittown, Pennsylvania; YOU'RE NOT ALONE by Liz McKinney, Good Samaritan Hospital, Portland, Oregon.

INTERGENERATIONAL PROGRAMS

An intergenerational program is an educational program that promotes the development of personal relationships between members of different generations. It is educational in that it creates an environment conducive to the development of a greater understanding of lifestyles, life choices, as well as quality of life issues by bridging the generation gap. It is also health enhancing by providing opportunities for well elders to engage in both physical and mental activities.

There are three broad classifications of intergenerational programs:

YOUTH ASSISTING ELDERLY

Examples are PROJECT MAIN, a nutrition program by Gerald F. Blake, Portland State University, Portland Oregon and CARE HOME CONTACT, a visitation program for the American Red Cross.

ELDERLY ASSISTING YOUTH

Examples are FAMILY FRIENDS PROJECT, which provides care for chronically ill and severely disabled children by the National Council on Aging, and AGELINK, a latchkey children's program from Center for Improving Mountain Living, Western Carolina University, Cullowhee, North Carolina.

COOPERATIVE

Examples are HISTORY SHARING THROUGH OUR PHOTOGRAPHS, an interactive discussion session, from Michigan Council for the Humanities, and OPERA AT THE PALACE, a musical interest program, from the Upper Arlington Senior Center, Upper Arlington, Ohio.

AUDIENCE AND SETTINGS

Intergenerational programs are flexible. They can be targeted to active or frail members of any age group. Settings for intergenerational programs are varied; some are simple, e.g., in an elder's home or a child's home, in school, etc. Other settings are very complex and involve travel to historic sites, to the nation's capital, to an opera, etc. Almost any setting can be adapted to an intergenerational program.

HEALTH PROMOTION EDUCATION
PROGRAM CATEGORIES

Health promotion education programs have been created to assist the older adult to maintain a positive self image; practice health promoting, problem solving and coping behaviors; and assume more responsibility for self-care. Health promotion education allows elders to take a more active role in their health maintenance, level of independence and quality of life.

Community-based settings for health education programs include senior centers, churches, schools and "town halls" or other civic activity centers. Programs which offer self-assisted learning may even be provided in the home through audio or video cassette.

Health promotion programs selected for review by the Center on Rural Elderly are those structured to provide the best opportunity for implementation in small towns and rural communities. The programs have been categorized by topic. The categories by topic are as follows:

PHYSICAL WELLNESS

Includes programs on such topics as exercise, hearing, vision, dental health, osteoporosis, foot care and smoking cessation. Examples are BODY RECALL by Dorothy C. Chrisman, Berea College, Berea, Kentucky; HAVE YOU HEARD by the American Association of Retired Persons.

MENTAL WELLNESS

Includes programs on such topics as memory improvement, mental alertness, self image, and loss and life changes. Examples include IMPROVING YOUR MEMORY by Lynn Stern and Janet Fogler, Turner Geriatric Services, University of Michigan Medical Center, Ann Arbor, Michigan; and GROWING WISER from Healthwise, Boise, Idaho.

NUTRITION

Includes programs on food choices, food preparation and nutrition practices which delay or minimize the effects of chronic diseases. Examples include CALCIUM FOR THE PRIME OF LIFE from Daniel J. Edelman, Inc., Washington, D.C. and NUTRITION EDUCATION FOR MINORITY/ETHNIC ELDERLY from the Association of Aging Services Dietitians of New York State.

MEDICATION EDUCATION

Includes programs on the appropriateness for elders of prescription and over the counter medications, drug interactions and side effects, and guidelines for self administration. Examples include SENIOR PREVENTION: A COMMUNITY BASED MODEL from the Regional Substance Abuse Center, Ames, Iowa, and A GUIDE TO USING DRUGS IN THE LATER YEARS, from S Rx Regional Program, San Francisco.

SAFETY

Includes programs which address safe environments for elders. Examples include SAFE RIDES FOR LONG LIVES from American Association of Retired Persons and HOME SAFE HOME from CLI Productions, Hyattsville, Maryland.

STRESS MANAGEMENT

Includes programs which assist elders in avoiding and coping with stress. Programs may have mental and physical components. Examples include PLANNING AHEAD: DON'T LET EMERGENCY HOSPITALIZATION CONFUSE YOU by Shirley Coudney, Montana State University and LIFETIME HEALTH, by the Lincoln Area Agency on Aging, Lincoln, Nebraska.

SELF RESPONSIBILITY

Includes programs which empower elders to take more responsibility for life style and health care choices and provide education on consumer products. Examples include WHAT YOU DON'T KNOW CAN HURT YOU by Shirley Coudney, Montana State University, and the PREP TALK FOR WOMEN by the National Center on Women and Retirement Research, Southampton, New York.

CENTER ON RURAL ELDERLY
HEALTH PROMOTION PROFILE

Essential Elements

* Subject area (single/multiple topic)
* Program developer or author
* Objective or purpose of program
* Target audience
* Recommended group size
* Program format and delivery method
* Availability (partial or complete program) on audio/video tape
* Resources required for implementation
* Evaluation information
* Time intensiveness (planning and implementation)
* Content discussion
* Characteristics of community, resources and supports, eg., transportation, meeting place, etc. that would provide "best fit" for program

Profiles are being developed for all program materials known to the Center in 1) Health Promotion, 2) Caregiving, and 3) Intergenerational Relations

RESOURCE GUIDES FOR COMMUNITY-BASED HEALTH PROMOTION EDUCATION PROGRAMS FOR THE ELDERLY

The resource guides include the rationale and goals of community education, considerations for educating older adults, information on how to complete a community assessment, and an annotated list of relevant materials available to the health service provider or community leader. Materials referenced in the Guide include audio-visual material aimed at the elderly audience; current literature on research and practice issues; materials designed to assist with the specifics of programming for health education; information on existing educational programs; and informational consumer handouts.

INTENDED AUDIENCE

These Guides are designed to be used as practical tools for individuals in the community who have varying degrees of experience in educational programming for the elderly.

CONTENTS

Each Resource Guide for Community-Based Health Promotion Education Programs for the Elderly will focus on one subject area. The following six guides are scheduled for production by mid-year 1990:

* Medication Education
* Nutrition
* Safety
* Mental Wellness/Stress Management
* Physical Wellness
* Self-Responsibility

HEALTH PROMOTION EDUCATION FOR THE RURAL BLACK ELDERLY: A PROGRAM DELIVERY GUIDE

This publication is designed to provide professionals and practitioners with practical ideas for adapting existing health promotion educational programs to the rural black elder. Innovative solutions to some of the common barriers to active participation in health education will be highlighted in the guidebook.

INTENDED AUDIENCE

The guidebook is designed with the needs of a wide variety of audiences in mind. Rural practitioners, with a wide variety of backgrounds and skill levels, will find practical suggestions for successfully involving rural black elders in health promotion efforts.

CONTENTS

Basic demographics on vital statistics and health status of the rural elderly are outlined. Age distribution, income, educational level, perceived health, and functional limitations are among the demographics included.

The current status of health education programming for rural black elders is examined. This section discusses some of the primary problems encountered in providing health promotion to rural black elders.

Examples of practical suggestions for adapting the structure and delivery of health promotion programs is the focus of this section. An assortment of ideas will enable the reader to select a number of strategies for making their own health promotion efforts more culturally-relevant for the rural black elder audience.

The guidebook concludes with examples of innovative health promotion programs which have proven successful in their efforts to provide rural black elders with health education information.

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7. RURAL ELDERLY: HEALTH CARE DELIVERY

JOYE A. MARTIN, M.D.
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Objectives:

Upon completion of this presentation participants should be able to:

1. List 3 barriers to health care delivery for the rural elderly.
2. Describe two basic urban-rural differences in the health care of elderly patients.
3. Describe at least one alternative delivery system for rural areas.
4. Use the information obtained during this session to formulate one strategy of health care delivery for rural elderly in his/her own locals.
5. Incorporate alternative health care delivery concepts into his/her geriatric curriculum.

RURAL ELDERLY: HEALTH CARE DELIVERY

by Joye A. Martin, M.D.

It would seem axiomatic in our society that health care should be available to all, regardless of race or socioeconomic status. Yet, providing of primary health care to those in rural areas, in particular the rural elderly, is one of the largest deficits in the U.S. Health Care System (6). As of 1989, 29.8 million Americans were age 65 and over (21), 95% of them living in communities outside nursing homes or other institutions. Preliminary data from the Supplement On Aging To The National Health Interview Survey, January-June 1984, indicates that 37% of those 65 years and older live outside a standard metropolitan statistical area (SMSA). These statistics mandate a closer look at health care delivery issues for the rural elderly, a sizeable segment of our population with significant barriers to obtaining needed health care.

RURAL - URBAN DIFFERENCES

Standard indicators of health show that rural elderly have more sickness and disability than urban elders, but receive less care (9, 14). Approximately 87% of rural aged have at least one chronic illness. They also have a greater number of restricted days of disability than their urban counterparts and demonstrate increased use of hospital care, yet see their physician less often (13). There are few home health services available for rural elderly. Rural elderly are more likely to be poor, have fewer safeguards against inflation (health insurance, retirement), live in substandard housing, have poor health, and have problems of accessibility due to inadequate transportation (7).

1986 ROBERT WOOD JOHNSON FOUNDATION STUDY

Access to health care services has historically been a problem for rural elderly. The Robert Wood Johnson Foundation (RWJF) funded a series of studies on access to health care in 1976, 1982, and most recently 1986. Freeman and his colleagues (7) conducted a telephone sampling of 10,130 people in the Continental United States concerning issues of health care accessibility. Personal interviews were also conducted with a small sample of people without telephones, and these findings differed only slightly, and not significantly, from those with telephones. This study concluded that:

1. There is decreased access to medical care for poor, uninsured, and minorities.

2. Between 1982 and 1986, there has been an overall decreased use of medical care, with less hospital utilization, and a decreased number of physician visits per person per year for <u>all</u> Americans.

3. The longstanding gap in receipt of medical care between rural and urban residents appears to have been eliminated (7). (This is not to say that there still remain isolated rural communities with poor access to health care.)

The ostensible "improved" access to medical care by rural people suggested by the RWJF study is illusory in regard to the rural elderly. Rural elderly were

not separated in this study. They have more chronic illness and restrictive disability. Therefore, their utilization of medical care should be proportionately greater than their urban counterparts. Thus, the RWJF study actually suggests that the rural elderly are receiving less care than appropriate for their level of health.

With few exceptions (such as the Robert Wood Johnson Foundation Survey), overall research on rural-urban differences has been scanty. When done, it is usually cross-sectional with small population samplings. It is thus difficult to make useful generalizations from such studies. Unless a broad based analyses is done, both cross-sectionally and longitudinally on rural and urban elderly, it will be difficult to establish a solid data base from which to make such useful generalizations.

BARRIERS TO HEALTH CARE DELIVERY

In developing a health care program for any rural area, a multiplicity of existent barriers to health care delivery must be considered. Looking at physician to population ratios may be erroneous because these ratios do not necessarily take into account demographic, geographic, economic, political, educational, and cultural variables.

For example, many rural elderly are geographically isolated. Transportation is difficult (13). Over 50% of the rural elderly do not own a car (1). Public transportation is not available in most rural areas due to the expense of operation. It is not uncommon to find unpaved, occasionally impassable roads. Rural elderly thus rely on family, friends, and neighbors to provide accessible transportation (8). But great distances can exist between friends, family and neighbors, leaving no one to reliably check on an isolated elderly person. The rural elderly frequently must travel far for hospitalization and other medical care.

Economic barriers to adequate health care are varied. Rural elderly are likely to have significant financial limitations. Increased cost of care, such as Medicare deductibles, restrictive co-insurance provisions, expensive medication, and health care costs not covered by Medicare or Medicaid are serious limitations to their ability to obtain reasonable health care. Some are not even insured.

More people in rural areas are without access to a telephone than those who live in towns and cities (2). Many, if not most, phone calls for health care services are long distance, a further financial burden for the rural elderly.

Rural elderly in general have a "crisis orientation" to health care (5). They possess a strong innate desire to maintain independence and are therefore self reliant. They depend on home remedies and consultation with family for primary health care. There is a pervasive underlying religious philosophy of "nature heals." Because of a strong work ethic, many rural elderly ignore or deny symptoms of illness until significant problems arise. There is a lack of awareness of health promotion/disease prevention and little long-term health care planning. This focus on acute health care, not infrequently resulting in

hospitalization, is very costly, both financially and emotionally, to the elderly patient and his or her family.

Inadequacy of social services presents another potential barrier to health care delivery. Young people tend to leave their rural home for employment, leaving their elderly relatives alone. The need for community resources becomes great. Even when community resources exist, the elderly individual (or his or her family), may have difficulty identifying and locating them (6). There is a lack of interagency coordination of the few services that do exist in rural areas. Elderly clients may feel their needs are already being met by informal supports (family, friends, neighbors), yet these informal supports may be stressed and in desperate need of community resources.

Attracting physicians to rural areas is another problem. Rural physicians feel overworked, with less time per patient. They lack back-up coverage. They feel a sense of isolation from colleagues, cultural opportunities, and educational opportunities. They may suffer from lower self-esteem because they look at themselves as generalists, who are not as productive as their urban counterpart due to such problems as travel time. These physician issues must be addressed if adequate health care delivery is to occur in rural areas.

Finally, previous emphasis has been placed on isolation - physical, social, economic and cultural (4). However, a rural area has the dichotomy of isolation and interdependence. "Most of the problems faced by today's rural America are precisely because the rural economy and its institutions are inexplicably interwoven with the national and international scene" (4). One example of this is Medicare reimbursement policies closing small rural hospitals. Large corporations frequently take over these hospitals and have no appreciation of the needs of the rural citizens in that locale.

ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS

Rural elderly are heterogeneous. The communities in which they reside are diverse. Given the previously mentioned barriers to health care for rural elderly, there is a need for creativity in the development of workable health care delivery systems. The traditional medical care model has not been cost effective, efficient, or accessible to the rural elderly. A better health care delivery system would be one that tailors the service to the individual rather than the individual to the service (10), providing flexibility with a willingness to provide services in a non-traditional way.

A variety of models of alternative health care delivery systems either exist or have been proposed. One such system is the community based nursing center. Nursing centers are nurse-run organizations that utilize nursing models of health and deliver broad based health care through 1) assessment of health needs of the community, 2) identifying and coordinating necessary community resources, 3) gaining community support, 4) improving accessibility by home visits, and 5) promoting health through functional assessment, health screening, and monitoring chronic disease (6). A nurse practitioner or physician assistant is the perfect health care provider for this type of community based center. As a client advocate, they bridge the gap between physician, acute care, home care, and long-term care.

Many other examples of non-traditional health care services exist. These include neighborhood health centers and their successors, the community health centers, satellite outreach health stations such as rural nurse practitioner or physician assistant clinics, hospital based primary care groups and clinics, HMO's, and mobile health clinics. "Grass Roots Advocacy" on behalf of the elderly can be effective in small rural communities. Local communities start their own programs and then develop relationships with formal planning agencies. Many such programs have been successfully developed, such as home health agencies, Meals On Wheels, Senior Companion Program for isolated homebound persons, and networking of Church groups and other volunteer groups for transportation, daily phone calls, and visits to elderly living alone.

MARSHALL UNIVERSITY/BENEDUM RURAL GERIATRICS PROJECT

In 1987, 13.9% of West Virginia's population was classified as 65 years or older, ranking the Mountain State 6th in the nation in proportion of elderly people (21). Fifty-six percent of these elderly reside in rural areas. With Marshall University's School of Medicine so intimately involved with rural health care, this setting is ideal for evaluation of an innovative, non-traditional health care delivery program for rural elderly. In recognition of this, the Department of Family and Community Health at the Marshall University School of Medicine was awarded a grant by the Claude-Worthington Benedum Foundation for the development and evaluation of a health care delivery system for isolated rural elderly. The project's goal is to improve the health care of a defined group of rural elderly in a cost effective, acceptable, and efficient manner. Improvement is to be gauged by prevention of hospitalization and long-term care placement, maintenance (or improvement) of function, containment of costs, and prevention of death and episodes of preventable disease. This project, if successful, should receive wide ranging application in many other rural settings.

To begin the project, a group of participants will be identified in Lincoln County, West Virginia. Lincoln county is rural, has relatively few health resources, and is largely serviced by a single, community owned primary health care center. Participants will be elderly citizens representing various living arrangements: couples, those living alone, those living with other family members, and those living in personal care settings. There will 100 control clients and 100 experimental clients. Both groups of subjects will receive baseline psychosocial evaluations using the OARS Assessment, environmental assessment, and on-going surveillance of health events and health expenditures. Medicare will assist in tracking health care costs for both groups of participants. The one pharmacy for the entire county has also agreed to help track pharmaceutical costs. The control group will have no other interventions except the baseline evaluation already noted and tracking of health care costs. The experimental group will additionally undergo a complete history and physical examination, including gait, mental status, perceptual capabilities (i.e., hearing and vision), nutritional assessment, and an evaluation of activities of daily living.

A health plan will be devised by a multi-disciplinary project team, and will be organized around selective problems which have been shown to contribute to preventable mortality and morbidity in the elderly of rural West Virginia. These include the following: prevention of accidents; depression and iatrogenic

illness; timely and convenient access to care for acute and chronic illness; improvement of nutritional and dental status; maintenance of mobility and daily living skills; social support; recognition and treatment of disorders of vision, hearing, gait, and urination; recognition and treatment of dementia; education of clients and family members. The project team includes a geriatric clinician (nurse practitioner or physician assistant), a primary care physician, social worker, care giver (if needed), and the occasional use of a geriatric consulting team (geriatric specialist, psychologist, physiatrist, occupational therapist, environmental safety specialist, and nutritionist from Marshall University School of Medicine). The geriatric clinician will act as team leader. Health care plans will be individualized, with revisions being made as needed. A computer program will be utilized for baseline data input and longitudinal tracking of medical costs, events (illness, hospitalization, ER visits, and accidents), mobility, life satisfaction, mental status, activities of daily living, course of chronic conditions, and nutritional outcome. Interventions will take several forms: home visits, transport to the primary care center, transport to a geriatric evaluation center at Marshall University School of Medicine if needed, or institutional care. Geriatric clinicians will manage care, supported by supervising primary care physicians and the project team. The overall philosophy of care will be oriented to prevention, rehabilitation, independence, self determination, and team care.

The purpose of this controlled prospective evaluation of a group of rural elderly is to identify what aspects of prevention are most beneficial and cost effective, and to identify reasonable predictors/risk factors of health/illness. The findings of the Benedum rural geriatrics project are to be utilized in the development of a computer program useful to all rural health care communities in the structuring of their own unique health care delivery programs.

CONCLUSION

If the future health of our rural elderly is to be optimized, it will be necessary to test a variety of approaches to health care, adapted to areas of limited resources and wide geographic dispersal.

"Rural elderly live differently. The difference is not as great as it was, but it is real. Health and disease are grounded not only in the biology of our species, but in our chosen environments and behaviors. We are, by and large, educated in caring for urban and suburban people. Those of us who chose to live and practice in rural areas must adapt. Where we find differences we must describe them, share them, and appreciate them." - Robert B. Walker, M.D.

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8. GERIATRIC DENTISTRY UPDATE

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Objectives:

Upon completion of this presentation participants should be able to:

1. Discuss ways geriatric educators may get professional assistance in developing or improving educational program elements focused on dental topics.

2. Describe the current core literature resources in geriatric dentistry which are available to educators and clinicians.

3. Explain the past, present, and future impact of dental and oral health services on the quality of life of older Americans.

4. Describe the efforts of professional dental educators to significantly expand and improve the quality of geriatric training in America's dental colleges and affiliated programs.

UPDATE ON GERIATRIC DENTISTRY
1989 SGI - 7/27/89

Moderator: Dr. Robert Henry

Presenters: Dr. Arthur Van Stewart
Ms. Jill Butters
Dr. Robert Henry

Introduction (Dr. Stewart)

Gerontology has not existed for very long as a recognized scientific discipline. Over the years people, including philosophers, politicans, priests, and scientists have wondered at the accomplishment of reaching an old age. However, only in the past half century or so has the formal study of aging and related conditions been considered a true field of scientific inquiry of comparable value and significance with other disciplines in the social sciences and humanities. Early efforts to understand the aging process were undertaken by sociologists, psychologists, physicians, and many types of the natural scientists. Among the professions most recently taking a sincere interest in geriatrics and gerontology is the dental profession. The purpose of this report is to provide an overview of the dental profession's current involvement in gerontology as of summer, 1989.

A few dental pioneers became deeply concerned about oral services to older persons many years ago. These individuals wrote the first articles, made the first scientific presentations, founded the American Society of Geriatric Dentistry, and helped to establish the Academy of Dentistry for the Handicapped. However, most of this effort was limited to very few individuals and might ver properly be described as falling outside of the mainstream of dental research, dental education, and dental practice. This situation remained fairly constant until the middle of the 1980's when a number of factors combined to encourage the

profession to undertake a series of new initiatives related to geriatric care. This session of the 1989 Summer Geriatrics Institute is much too short to discuss these forces in any detail; however, demographics, changes in the need/demand for traditional types of dental services, recognition of patient profile changes in the Veteran's Hospital system, and the impact of the nationwide preventive dentistry program all can be seen as major contributors.

While dentistry itself has begun to take an increasing interest in geriatric care, many of the other professions already involved in gerontology and geriatrics have not yet recognized dentistry's current efforts or new capabilities. This problem can easily be exemplified by something which happened at this very Institute, specifically the feature presenter's comments on Wednesday morning. This highly trained and extremely sensitive professional started her talk by asking people in the audience to identify themselves by their academic training or professional responsibilities. You may recall that she went through 10 or 12 separate care-giving disciplines without once thinking of dental personnel as possible program participants. This is both telling and misleading. In actual fact dentistry has 12 program participants at this year's SGI larger than the number of pharmacists, physicians, social workers, nutritionists or any other single professional group, with the single exception of nurses.

A major thrust of the University of Louisville Geriatric Dentistry Program during 1988-89 has been to take dentistry to the other gerontologically involved professions. Presentations, papers, and newspaper articles have all been created to raise the awareness of other

professional groups and the lay public to the services and opportunities which can be provided by dentistry. In a comparable way, an effort has been made to alert all dentists to the opportunities, responsibilities, and realities of geriatric dentistry. For example, since the major thrust of gerontological care today is focusing on the quality of life, clearly there is a very major role for dentists, dental hygienists, and dental specialists in the provision of quality care for older persons.

During this session we will review these new developments by looking at five separate dimensions of geriatric dentistry: (a) undergraduate dental school training, (b) graduate and postgraduate professional training, (c) involvement of the dental hygienists, (d) national leadership activities, and (e) a discussion of some of the key factors influencing geriatric services now and in the near-term future.

Undergraduate (DMD/DDS) Training (Dr. Stewart)

The dental schools are not overlooking the need to improve the training of the nation's dentists to better serve an aging population. The American Association of Dental Schools (which includes U.S. and Canadian institutions) has used its faculty advisory committees to produce formal, written "Curriculum Guidelines for Geriatric Dentistry Education" which have been approved and adopted. While not an official accreditation document (dental schools are reviewed by the Commission on Dental Accreditation of the American Dental Association [CODA]), it has a very similar impact on curriculum committes, academic deans, and others involved with planning and managing the dental schools. Dental schools now being site-visited and reviewed by CODA accreditation teams must

demonstrate the existence of an active geriatric dentistry program in order to be in compliance with AADS and CODA/ADA expectations.

In 1988, the AADS received a grant from the Institute on Aging which supported three national workshops to help dental administrators and dental faculty to initiate or upgrade their geriatric dentistry programs. All schools were invited to send one or two delegates (a faculty member and an administrator) to attend one of these regional workshops. Participants in the workshops not only benefited from the program, but also met the authors of a new geriatric dentistry workbook which was given to each of the participants. The workbook provided outlines of teaching materials, extensive bibliographic references, and lists of contact persons and resource materials for use by the program participants. More than 140 people took advantage of these workshops.

In addition to these three regional workshops, a "special interest group" within the American Association of Dental Schools was created so that faculty, students, and administrators attending the annual AADS meetings could get together and exchange information about ongoing and developing geriatric dentistry programs. The first of these special interest group meetings was held in San Francisco in March, 1989. Another is scheduled for the Association's 1990 meeting in Cincinnati.

Another significant change in the professional environment was the publication of two high quality textbooks in the field, their titles being "Oral Health and Aging" (Ames Tryon, 1986) and "Geriatric Dentistry" (Pedersen, 1986). These two books offered students, faculty, and practicing clinicians a great deal of information about the effects of aging on the anatomy, physiology, biochemistry, and microbiology of

the stomatognathic system. They also provided valuable suggestions concerning the management and treatment of the older patient. Both books now are used as required texts in American dental colleges.

It is expected that by 1990 all AADS member institutions will have active and effective geriatric dentistry programs available to their dental students, either as freestanding "geriatric dentistry programs" or as portions of interdisciplinary training programs in "hospital dentistry," "special patient care," "public health," "community health," or some other comparable educational format. The dental students graduating in the late 1980's and in the future will know more about aging and are expected to be capable of providing better treatment to the increasing numbers of older people expected to be seen in their practices.

Graduate and Postgraduate Dental Training (Dr. Henry)

At the same time that efforts are being made to improve the training of undergraduate dental students, a comparable effort has also been made to strengthen the postgraduate and residency programs offered by the profession. These efforts fall broadly into two categories. One of these is related to the training of dental specialists, and the other is related to the preparation of more fully trained general practitioners.

At the University of Louisville for example, the Geriatric Dentistry Program works with postgraduate students in Oral Biology (M.S. candidates), endodontists, prosthodontists, and to a lesser degree, periodontists and oral surgeon residents. These graduate level students will participate in literature reviews, seminars, and case studies

involving older patients who display a number of different problems and considerations.

An even greater focus on geriatric dentistry will be included in the General Practice Residency Program (hospital based) and the new Advanced General Education Program (school based). These postgraduate training programs have included both didactic and clinical activities in geriatric dentistry. At the University of Louisville and the University of Kentucky, the GPR dentist spends part of their training treating community nursing home and home-bound elderly under faculty supervision.

At the University of Kentucky and the University of Cincinnati, special "Geriatric Fellowship Programs" have been started with federal funding which will give dentists and/or faculty the opportunity to further their training in gerontology and geriatric dentistry. These two-year programs are designed to prepare dentists as clinicians, teachers, administrators, and researchers in geriatric dentistry. There are 22 such programs which have been funded (including the University of Kentucky and Cincinnati), and are innovative in that two of the three positions per site are reserved for physicians and one is for dentists, thus the training is of necessity cross-disciplinary.

In addition to these programs, some schools are closely linked with the Veteran's Administration Medical Centers which often have dentists who have received specialized training in Geriatric Dentistry from one of the six VA programs in the country. Many of these dentists, who have been trained in the VA programs, are currently VA hospital staff and are active in teaching positions at the affiliated university to undergraduate or graduate level students.

There are more dentists in training as geriatric fellows in 1989 than have been trained in geriatric care since formal training in dentistry began at Baltimore in 1887. In the next 10 years, an estimated 400 dentists could be trained in "geriatric" advanced dentistry programs if federal funding is continued and if the professional marketplace has the capability to absorb and use such an impressive number of specially prepared dentists. It should be noted, moreover, that it is not the intent of these training programs to withdraw these practitioners by offering a specialty, but to have better trained dentists in the community, on faculties in dental schools, and in all types of clinical care systems (hospitals, nursing homes, etc.).

Dental Hygiene (Ms. Butters)

Hygienists are well trained oral health professionals and can be an invaluable resource in two distinct aspects of geriatrics: (a) geriatric education and (b) clinical geriatric care; however, several political, legal, and professional barriers combine to reduce the current effectiveness of the nation's dental hygienists in helping with dental care for older persons. One factor which probably is contributing to this unfortunate situation is reaction to some of the efforts of selected dental hygiene leaders to espouse independent practice. This is a divisive issue and has produced generally negative reactions from most members of the dental profession to their efforts. These concerns are magnified by a rash of other disputes related to "illegal dentistry" activities involving unlicensed and untrained persons making and selling "false teeth." These separate phenomena have confused the general public

and their advocates, such as AARP. They also have persuaded the dental profession to monitor the laws of their states very carefully, especially when they relate to (a) the supervision of auxiliaries and (b) the definition of "assignable" clinical functions.

Dental hygienists have much to offer as a result of their special training in maintaining oral hygiene, including tooth cleaning, removal of stains and calculus, and care of the periodontium. In addition to these obvious clinical skills, dental hygienists also have a great potential to become part of research activities, especially those dealing with health care policy issues. Other roles for which hygienists are particularly well-suited include serving as health educators and as technical, educational, or clinical consultants to many types of geriatric educators or geriatric care providers.

The American Association of Dental Schools is fully aware of the need to upgrade the geriatric training of dental hygiene students and has been successful in getting an additional federal grant so that another national conference may be held in March, 1990. This conference on Geriatric Dentistry for the Dental Hygienist will be held at Louisville, Lexington, or Cincinnati, Ohio and will follow the same general format as the 1988 workshops conducted for dental faculty last year. Only one workshop will be offered to dental hygiene educators, however, since funding is more limited. A second workbook will be produced as a guide to dental hygiene educators (many of whom are not associated with dental schools). This workbook will have the same general outline as the workbook produced for undergraduate dental education <u>but</u> will have five

additional chapters: ethical/legal issues, continuity of care, quality assurance, health education, and the role of the dental hygienist.

National Leadership Activities (Dr. Stewart)

While professional education has been actively strengthening its efforts on behalf of older Americans, the American Dental Association and other professional organizations also have been taking steps to become more effective advocates for oral health of older people. In May, the Federation of Special Patient Care Organizations (American Association of Hospital Dentists, American Society for Geriatric Dentistry, and American Association of Dentistry for the Handicapped) met to consider their mutual and separate roles in the provision of care for specialized types of patients. This first-ever meeting was a great success, and another is planned for the spring of 1990. Faculty and students (including residents and dental hygienists) are being encouraged to join one or more of these groups so that they can have closer contact with these groups, participate in their meetings and journals, and be in a position to offer their own ideas and suggestions for ways to make the desired improvements in geriatric care-giving.

In a similar but different way members of the dental profession have made efforts to become more active in other groups such as the AARP, the AGHE, GSA, ICG, and a host of other local, regional, national, and international associations which are dedicated to geriatric care, geriatric research, and/or gerontology.

Faculty and others interested in research are presented with a plethora of grant and contract opportunities, both from the federal

government and from private sources such as the Robert Wood Johnson Foundation and the Andrus Foundation. A new dental section has recently been created by the International Association for Dental Research (Geriatric Dentistry Section) in order to give researchers and others a greater opportunity to present the results of their work and to share ideas about present and future research efforts and activities.

Factors Influencing Geriatric Dentistry Now and in the Near Future

While geriatric dentistry has made very significant strides in the last few years, a number of critical problems continue to exist which, if not resolved, will probably hinder its future development. Unless these issues are eliminated or at least significantly reduced, the attitudes toward dental services will remain the same, and the quality of care will continue to be well below the profession's potential to serve the older public.

a) Dentistry's estrangement from AARP. Unfortunately, AARP does not see dental services as a major problem for its membership/clients. In no form does dental service exist on the AARP's list of political or medical issue priorities. AARP has occasionally sided with oponents of the ADA on certain types of policy matters. This is further exacerbated by the fact that ADA has not established an effective liaison with the AARP leadership. As a result of these failings, AARP (the nation's most important advocate for older persons) has yet to discover the value of dentistry and dental services.

b) Poor professional image. Probably i manyt professions, but certainly in the dental profession, gerontology is not a very highly

regarded aspect of overall responsibility. Among all dental specialities and dental sub-specialties, it might even be regarded as the "lowest man on the totem pole." Hopefully, as the quality of people entering this discipline continues to rise, this may change. However, the rate and method of compensation are expected to continue to fall well below the income levels of other practitioners with graduate training. This almost certainly will continue to detract from the image of the geriatric dentistry practioners. As most of you recognize, this is merely another aspect of the generally negative attitudes of the general public and the general practitioners toward geriatric care and its associated institutions and agencies.

c) Lack of fee payment systems. The number one barrier to dental care for older persons is the lack of federal and/or state compensation for such services. The payment program is so dismal that many key figures in the field feel that the only viable method of securing dental services for the elderly, especially the elderly indigent is to establish a large and effective volunteer system (such as the Donated Dental Services Program at the national level or the new denture program sponsored by the KDA in Kentucky). While many older persons can afford private fees for dental service, a large and increasing number of others need external support in order to secure even the most basic of their needed services.

d) Lack of long-range planning. Many of the latest initiatives have been stimulated by federally sponsored grants and contracts. While these are having a positive impact and are greatly appreciated, dental education has an extensive history of following federal leadership and

initiatives only as long as financial rewards are available. Also, it is not very likely that the federal government will continue to fund workshops and fellowship indefinitely. Some leadership groups need to establish themselves as the planners for the time following the withdrawal of federal (and maybe even private) support systems.

e) Re-alignment of ADA priorities. The ADA has been involved in monitoring and supporting several forms of federal and state legislation, including the Omnibus Reconciliation Act of 1987, which will have a direct impact on oral health care in nursing homes which care for Medicaid patients. However, this seems to be less than what could be done and is well down on the list of priorities of the ADA leadership and ADA membership.

f) Lack of focus on "choke points." The dental profession has a limit to the amount of time and effort it can expend on behalf of older Americans' health and safety. As things work today, there is an almost random application of these efforts to issues at all levels of health care and politics. The problem is one of distinguishing "BIG" from "LITTLE." Choke points (pressure points) exist in every system, and the same amount of political or professional pressures applied at these points can have a disproportionate impact on policy, performance, and product. As we all recognize, universities and even dental schools are exquisitely sensitive to the slightest changes in accrediation regulations and requirements. Very large amounts of money can suddenly be applied to educational programs in order to bring them and/or their whole university into compliance. The dental profession needs to be more sophisticated in its approach to dental care for older persons. In

addition to affecting a positive working relationship with AARP and the federal government on some key issues, it should also volunteer to become members of nursing home boards and learn to work with community agencies and older person ombudsmen; it should encourage optimal utilization of the dental hygiene profession in the provision of care to the elderly; it should make appointments to nursing home staffs more responsible; it should use state board members (or similarly powerful persons) to serve on site-visit teams for the state accrediting and licensure boards for long-term care facilities; and it should prepare its own set of standards for oral health care and treatment for institutionalized older persons in each of the many types of health care facilities which exist today. The alternative is to let nursing home administrators, their professional staff members such as nurses and physicians, or more likely their non-professional staff members, such as nurses aides make these decisions for the profession and develop their own "rules of the road" and establish the operational standards of care.

This is only a very brief summary of the status of geriatric dentistry as it exists in 1989. The field has a great tradition of caring for the older patient. It is now girding for the more responsible role of care for millions and millions of older Americans, with both the absolute and relative numbers growing with each decade into the foreseeable future. These older persons are looking for a better lifestyle than has existed for future generations. They also will have more teeth and greater needs of many kinds for dental care. Dentistry is preparing to accept the challenge to meet political, economic, social, and professional needs of the new age of older persons. Let us hope that we can be supported by our other professions and our elderly patients themselves.

9. GERIATRIC NURSING UPDATE

TERRY T. FULMER, PH.D, RN, C
SCHOOL OF NURSING
YALE UNIVERSITY

Objectives:

Upon completion of this presentation participants should be able to:

1. Analyze the goals and competing agendas that influence nursing care.
2. Discuss leadership strategies for changing the system.
3. Propose strategies for implementing new research findings into daily practice.

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